STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/25/2018 - 04/27/2018.	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 reviews and interviews, the facility failed to assure 2 of 6 sampled staff (Staff A, D) were tested upon hire for Tuberculosis (TB) disease. The findings are: 1. Review of Staff A's personnel file revealed: -Staff A was hired 09/09/14 as a Medication Aide (MA). -There was no documentation of a TB skin test between 09/09/14 and 07/29/17. -There was documentation of a TB skin test placed on 07/29/17 and read as negative on 08/01/2017. -There was no documentation of a second TB skin test for Staff A since her hire date. Interview with Staff A (medication aide) on 04/27/18 at 3:54pm revealed:	D 131		

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-She had been an employee of the facility since 2014.
-She had a TB skin test at her previous employer in 2014, "we had to have one every year."
-She had continued to have a TB skin test yearly at her physician's office until this year, 2018.
-The Administrator had given her a TB skin test this year, 2018.
-She did not know why there was not a copy of the one she had received this year in her employee file.
-She would contact her physician's office to obtain a copy of previous TB skin tests.

Interview with the Administrator on 04/27/18 at 2:54pm revealed:
-She did not recall if a second TB skin test had been completed for Staff A.
-She would complete Staff A's second TB skin test this date, 04/27/18.

Refer to interview with the Business Office Manager (BOM) on 04/27/18 at 2:34pm

Refer to interview with the Resident Care Director on 04/27/18 at 2:54pm

Refer to interview with the Administrator on 04/25/18 at 9:45am and 04/27/18 at 4:30pm.

2. Review of Staff D's personnel file revealed:
-Staff D was hired on 06/19/17 as a Personal Care Aide (PCA).
-There was documentation of a TB skin test placed on 02/13/17 and read as negative on 02/15/17.
-There was no documentation of a second TB skin test for Staff D since his hire date.

Interview with the Administrator on 04/27/18 at

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D 131	Continued From page 2 2:54pm revealed: -She did not recall if a second TB skin test had been completed for Staff D. -She would complete Staff D's second TB skin test the next time he worked, she was not sure of the date. Attempted telephone interview with Staff D on 04/27/18 at 3:59pm was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 04/27/18 at 2:34pm Refer to interview with the Resident Care Director on 04/27/18 at 2:54pm. Refer to interview with the Administrator on 04/25/18 at 9:45am and 04/27/18 at 4:30pm. Interview with the BOM on 04/27/18 at 2:34pm revealed: -She was responsible for maintaining personnel files. -The Administrator completed the staff TB skin tests and provided the paperwork for her to file. -She tried to audit the personnel files annually; she had not audited the personnel files in the past year. -The TB skin test were on the audit form. -The staff without a second TB skin test "fell through the cracks." Interview with the Resident Care Director (RCD) on 04/27/18 at 2:54pm revealed: -She was responsible for assuring staff had TB skin tests completed. -She asked new employees if they had a TB skin test in the past year and to bring a copy for their employee file. -If they had a previous TB skin test she would do	D 131		

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D 131	Continued From page 3 their second TB skin test; if they had not had one she did the two TB skin tests.. Interview with the Administrator on 04/25/18 at 9:45am and 04/27/18 at 4:30pm revealed he referred all nursing and survey questions to the Resident Care Director (RCD).	D 131		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, and interviews the facility failed to assure food preparation tables, food preparation table legs, plastic storage rack shelves, clear plastic storage containers with white lids, plastic dishwashing racks, dry food storage area shelves and floor, food transport cart, reach-in refrigerator, reach-in freezer, stove, kitchen floors, clear plastic containers without lids and white plastic storage container with wheels were cleaned. The findings are: Observations of the food preparation tables on 04/25/18 at 10:54 am revealed: -The bottom shelves of three of three tables had stains and crumbs collected along the edges. -The four corners of the bottom shelf of one of three tables had brownish stains near the legs of the table.	D 282		

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D 282	Continued From page 4 Observations of the food preparation table legs on 04/25/18 at 10:54 am revealed the table in the center of the kitchen had brownish stains along the entire length of four legs. Observation of the plastic storage rack shelves in the center of the kitchen on 04/25/18 at 11:32 am revealed: -The shelves had crevices along the edges and corners. -Each crevice along the eight shelves contained bits of paper, wrappers, crumbs, and other food debris. Observation of the clear plastic storage containers with lids on 04/25/18 at 10:48 am revealed: -The containers stored cereal, coffee, coffee filters, oven mitts, and condiments. -There was a sticky residue that varied in color between the six white lids. -There were crumbs on three of six white lids under the food preparation table holding the blender. -There were crumbs and other food debris inside six of the containers. Observation of the plastic dishwashing racks on 04/25/18 at 11:32 am revealed: -There were black stains between each divider on the white border of eight of eight racks. -There was discoloration along the sides of eight of eight racks. -Four of the racks were stored on the floor under one of the dishwashing tables directly in front of containers of cleaner. Observation of the dry food storage area shelves and floor on 04/25/18 at 2:12 pm revealed:	D 282		

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D 282	Continued From page 5 -The eight shelves had a dusty residue. -The floor had debris behind each set of shelves, the canned food holder and behind the dry food storage area door. Observation of the food transport cart on 04/25/18 at 11:23 am revealed: -There were crumbs collected along the crevices of the two handles on the cart. -There were crumbs along the bottom edges of all four sides of the cart. -The upper and lower compartments of the cart had stains and crumbs on the inner doors. -The upper and lower compartments of the cart had crumbs at the base of the compartments. Observation of the two door reach-in refrigerator on 04/25/18 at 11:19 am revealed: -There was white residue on each door handle. -There were white stains along the full length of the vents on the front lower portion of the refrigerator. -On the inside, there were brownish stains and bits of food debris along the full length of the bottom of the refrigerator. -There were crumbs collected in the grooves of the gaskets on the inside of both refrigerator doors. Observation of the three door reach-in freezer on 04/25/18 at 11:26 am revealed: -There were stains and crumbs on the bottom portion of the freezer. -There were crumbs in the grooves of the gaskets on each door. -There were six of six metal racks with peeling paint and rust. Observation of the gas stove top on 04/25/18 at 10:51 am revealed	D 282		

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D 282	Continued From page 6 -There was a thick layer of grease and dirt around four of eight grate burners. -There were crumbs around and between eight grate burners. -There were stains around eight burners. -There were brownish stains on the work shelf directly in front of the stove burners. Observation of the kitchen floors on 04/25/18 at various times between 10:49 am and 11:32 am revealed: -There were food wrappers, bits of paper, crumbs and food debris behind the 3 food preparation tables near the walls. -There were crumbs and unknown debris behind and beneath the 2 dishwashing tables. -There were crumbs and unknown debris in the corners of the kitchen floor. Observation of the white plastic storage container with wheels on 04/25/18 at 11:23 am revealed: -There were crumbs at the bottom of the storage container. -The majority of the crumbs had collected in the corners of the storage container. -There were crumbs and stains along the outer upper rim and sides of the storage container. Observations of two clear plastic containers in the cleaning storage area on 04/25/18 at 2:17 pm revealed: -The containers were on the floor of the storage area. -The containers were between the bottom shelf of a metal storage rack and the floor-set mop sink. -There were boxes of cleaner, bleach, mops, bucket and a funnel near the containers. Observation of the range hood on 04/25/18 at 10:53 am revealed a layer of grease covered the	D 282		

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D 282	Continued From page 7 hood. Review of the kitchen food inspection report dated 01/11/18 revealed a kitchen sanitation grade of 99. Review of the notebook that contained cleaning logs on 04/25/18 revealed all of the logs were dated October 2016. Interview with the Dietary Manager (DM) on 04/25/18 at 10:45 am revealed: -She was responsible for the dietary staff and the day to day kitchen operation. -The plastic storage container with wheels was not used and had not been used for a year. Interview with the dietary aide (DA) on 04/25/18 at 2:00 pm revealed he did not know why the containers were placed on the floor. Interview with the same DA on 04/25/18 at 10:42 am revealed the white plastic container with wheels was used to store excess bread when a delivery was made. Interview with another DA on 04/27/18 at 9:30 am revealed: -She had worked at the facility for one to two weeks, she could not remember. -She was still learning what needed to be done. -She was told by the DM the areas of the kitchen she needed to clean. -Each time she worked at the facility she cleaned the kitchen floors, the food preparation tables, the dishes, the dining area and anything else the DM needed her to clean. Interview with the DM on 04/26/18 at 8:35 am revealed:	D 282		

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D 282	Continued From page 8 -There was a cleaning schedule for the kitchen area. -The cleaning schedule and logs were maintained in a notebook in the kitchen. -The cleaning logs were thrown away a month ago when they became wet. -She did not request new cleaning logs from the Business Office Manager (BOM). -The cleaning logs were not reviewed and she expected the cleaning to be completed by the staff. -The entire dietary staff was responsible for maintaining a clean kitchen. -When staff did not perform a task as instructed, she reported the issue to the BOM. -The BOM was her supervisor and the Resident Care Director (RCD) provided the diet orders to dietary. -There were new staff members in dietary and she trained them when there was an adequate number of staff in the kitchen. -She was aware of the build-up of grease and dirt on the stove. -She did not know how to clean the stove in order to remove the build-up of grease and dirt. -She had not asked anyone what could be used to clean the stove. -The stove was wiped down daily with a wet cloth. -She would ask the BOM what could be used to clean the stove. -She knew about the brownish stains on the legs of the food preparation tables. -A scouring powder was previously used to clean the legs of the tables. -She would ask the BOM what could be used to clean the table legs. -The food preparation tables were cleaned daily with a pot and pan cleaner. -She thought the stains at the corners of the table were caused when cans were opened with the	D 282		

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table attached can opener.
-The white plastic container with wheels was not used and it had not been used for three years.
-She thought she had recently washed the white plastic container with wheels, but she was unsure.
-The white plastic container with wheels would be thrown in the trash.
-The clear plastic containers with white lids were cleaned once a week.
-She knew about the stains and crumbs at the bottom of the refrigerator and freezer.
-She did not know about the crumbs in the grooves of the gaskets on the refrigerator and freezer doors.
-The staff were expected to clean these areas when they discover them.
-She did not know about the splattered stains on the vents of the refrigerator.
-The dishwashing racks were not cleaned.
-She did not know about the black residue on the dishwashing racks.
-The food transport cart was cleaned one week ago with pot and pan cleaner.
-The plastic storage racks in the middle of the kitchen were purchased this year.
-The plastic storage racks had never been cleaned.
-The floors were cleaned daily.
-The pot and pan cleaner was used for the floors.
-She did not know about the debris on the floors near the walls behind the tables in the kitchen.
-She did not know about the debris on the floors of the dry storage area in the corners.
-The range hood was cleaned by the Maintenance Director (MD) and he cleaned it a few months ago.
-The clear containers in the cleaning storage area were used for meats
-The containers had not been used for six years.

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D 282	Continued From page 10	D 282		

-She was not aware of who or why the containers were placed on the floor.
-She was aware that the containers could not be stored on the floor because of "bacteria and dirt."
-She was responsible for ensuring all areas of the kitchen were cleaned.

Interview with the MD on 4/26/18 at 10:50 am revealed he did not clean nor maintain the range hood.

A second observation of the food preparation tables on 04/27/18 at 3:50 pm revealed the bottom shelves, edges and corners did not have crumbs or stains.

A second observation of the facility kitchen on 04/27/18 from 3:50 pm to 4:23 pm revealed:
-The brownish stains remained on the four table legs of the food preparation table.
-Debris remained in the crevices of the plastic storage racks.
-The black stains and discoloration remained on eight dishwashing racks and four plastic dishwashing racks remained on the floor under the dishwashing table.
-Dusty residue remained on eight of the dry food storage area shelves.
-Debris remained on the floor behind each set of shelves, the canned food holder and behind the dry food storage area door.
-The crumbs and stains remained on the food transport cart handles, bottom edges, and inner compartments.
-The thick layer of grease and dirt remained on the gas stove top burners.
-The clear plastic containers remained on the floor of the cleaning storage area.

A second observation of the clear plastic storage

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containers with lids on 04/27/18 at 4:05 pm revealed the three of six lids were clean.

A second observation of the white plastic storage container with wheels on 04/27/18 at 4:10 pm revealed the container was removed from the kitchen.

Interview with the BOM on 04/27/18 at 8:30 am revealed:
-She supervised the dietary staff.
-She was responsible for dietary services, the staff and for making sure the staff followed the cleaning schedule.
-The dietary staff had a cleaning schedule to follow.
-She thought the staff followed the cleaning schedule.
-She expected the dietary staff to be responsible adults.
-She met with the dietary staff a month ago to discuss the job responsibilities and her expectations.
-She met with the dietary staff, because she wanted to review those responsibilities with the new staff members.
-She expected the dietary staff to clean up spills, and dispose of trash when discovered.
-She did not review the cleaning logs.
-She made "rounds" after the first shift left for the day but not daily.
-She did not look inside the refrigerator or freezer when she made rounds.
-She also looked over the kitchen when the delivery truck came each week on Wednesdays.
-She did not know about the debris on the floor.
-She did not know about the residue on the clear plastic containers.
-She thought the clear plastic containers were pressure washed recently by the dietary staff.

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D 282	Continued From page 12 -She did not know about the debris and residue on any of the racks. -She did not know about the clear plastic containers stored on the floor of the cleaning storage area. -The range hood was maintained by an outside company. -The company sent a technician every six months and performed maintenance. -She planned to talk with the staff and make frequent rounds. Interview with the Resident Care Director (RCD) on 04/26/18 at 4:15 pm revealed: -She did not know the dietary staff did not have any cleaning logs. -The cleaning log form could be printed and given to the dietary staff when needed. -She expected the DM to request the cleaning logs when needed. -No one made her aware of the items that were not clean in the kitchen, and dry storage areas. -The DM gave her a list of items that were not cleaned in the kitchen and dry food storage area that day. Interview with the Administrator on 04/25/18 at 9:45 am and 04/27/18 at 4:30 pm revealed he referred all nursing and survey questions to the RCD.	D 282		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be	D 283		

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D 283	Continued From page 13 protected from contamination. This Rule is not met as evidenced by: Based on observations, and interviews the facility failed to assure that the ice machine and ice machine scoop, which was stored on top of the ice machine, was clean and free from contamination. The findings are: Observation of the ice machine on 04/25/18 at 11:25 am revealed: -The inner upper gasket had a thin line of black mildew/mold along the edge. -The gasket was directly above the ice cubes. -There was dust and a grayish residue on the outer top of the machine. Observation of the ice machine scoop on 04/25/18 at 11:25 am revealed: -The scoop laid on the top of the ice machine. -The scoop was not covered nor was it in a protective holder. Interview with the Dietary Manager (DM) on 04/25/18 at 4:45 pm revealed: -She knew that the ice machine scoop was on top of the ice machine. -There was a blue ice scoop holder that was attached to the front upper portion of the ice machine. -She came to work last week and the holder was not in place on the ice machine. -She was told by a dietary aide that an employee threw it away. -The facility would order another one. A second observation of the ice machine scoop on 04/27/18 at 3:52 pm revealed:	D 283		

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D 283	Continued From page 14 -The ice machine scoop was placed in a small clear plastic storage container with a white lid. -The container was stored on top of the ice machine. -A second ice scoop wrapped in a plastic wrapper was also on the top of the ice machine beside the small clear plastic container. Interview with the DM on 04/26/18 at 8:35 am revealed: -There was a cleaning schedule for the kitchen area. -The cleaning schedule and logs were maintained in a notebook in the kitchen. -The cleaning logs were thrown away a month ago when they became wet. -A request for more cleaning logs would be made to the Business Office Manager. -The Business Office Manager (BOM) supervised the dietary staff. -She knew that the ice machine should be cleaned. -She cleaned the ice machine but was unsure of the date it was last cleaned. -She knew that the mildew/mold was on the gasket and would need to be cleaned. Interview with the BOM on 04/27/18 at 8:30 am revealed: -She supervised the dietary staff. -She "assumed" they were following the kitchen cleaning schedule. -The DM had asked for additional cleaning logs. -The ice scoop had a holder and she was not made aware the holder was thrown away. -The staff knew the ice scoop could not be placed on top of the ice machine because they took the food service orientation test. -A replacement holder for the ice scoop would be ordered	D 283		

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D 283	Continued From page 15 -She made rounds through the kitchen intermittently after the first shift left. -She did not make rounds after the second shift ended which was 7:00 pm. -She planned to begin making rounds more frequently. Interview with the Resident Care Director (RCD) on 04/26/18 at 4:15 pm revealed: -The BOM was the supervisor for the dietary staff. -The DM made her aware that day of what needed to be cleaned. -The staff had not made her aware of the ice scoop holder or the mold in the ice machine. Interview with the Administrator on 04/25/18 at 9:45 am and 04/27/18 at 4:30 pm revealed he referred all nursing and survey questions to the RCD.	D 283		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure that	D 299		

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residents in the Assisted Living (AL) and the Special Care Unit (SCU) were served milk twice daily.

The findings are:

1. Review of the resident roster (not dated) revealed the census in the AL was 34.

Review of the facility cycle 1 menus for the week of 04/22/18 through 04/28/18 on 04/26/18 revealed milk was listed on the menu for all three meals each day.

Observation of the refrigerator on 04/25/18 at 11:25 am revealed:
-Three full gallons of 2 % milk were available to be served.
-A food truck order was delivered to the facility on 04/25/18 at 12:30 pm.
-A follow-up observation of milk was not observed.

Observations of residents during the breakfast meal service in the AL dining room on 04/26/18 between 7:55 am and 9:07 am revealed:
-Thirty-four residents were served coffee, and water for breakfast.
-There were 4 of 34 residents who were served milk.
-The milk was placed on the table prior to the resident's arrival.
-Milk was not offered to any residents during the breakfast meal.

Observations of residents during the lunch meal service in the AL dining room on 04/26/18 between 12:07 pm and 12:40 pm revealed:
-Thirty four residents were served water, and tea for lunch.

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D 299	Continued From page 17 -Thirty-four residents were not offered milk during the meal. Interview with an AL resident on 04/26/18 at 9:05 am revealed: -The resident has resided at the facility for six months. -The resident had never been offered milk. -The resident had not asked for milk. -A resident who sat beside her received milk with her meals. -The resident would like milk to drink sometimes. Interview with a second AL resident on 04/26/18 at 11:15 am revealed: -The residents could ask for milk and it was provided to them. -Milk had never been offered for any meal. -The resident had not asked for milk only creamer for coffee. Interview with a third AL resident on 04/26/18 at 10:55 am revealed: -The resident received milk with cereal in the morning. -The resident ate cereal every morning and milk was placed on the table prior to his arrival. -The resident was not offered milk at any other meal that he could recall. -The residents could ask for milk and it was given to them. -The resident had asked for milk and it was provided. Interview with a personal care aide (PCA) on 04/27/18 at 8:50 am revealed: -The PCA had worked at the facility for twelve years. -The residents were not offered milk daily. -When residents asked, they were served milk.	D 299		

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D 299	Continued From page 18 Interview with a dietary aide (DA) on 04/27/18 at 9:15 am revealed: -The DA had worked for the facility for seven months. -Another dietary staff member who no longer worked for the facility trained him. -The current Dietary Manager (DM) retrained him. -The resident's diet directed what was given for beverages. -The DM clarified any questions for dietary staff about what beverages to serve to a resident. -Milk was offered to the residents during special events. -The last time milk was offered by the DA was February 2018 during an activity at the facility. -Milk was also served to specific residents who had requested milk previously during the breakfast meal. -The DA had not been told to offer milk during breakfast, lunch or dinner. -If a resident asked for milk, it would be given to the resident. Interview with a second DA on 04/27/18 at 9:30 am revealed: -She prepared beverages for residents, according to a list in the kitchen which included milk. -The list indicated what each residents' preference. -She served milk according to the residents' preference. Interview with the Dietary Manager (DM) on 04/27/18 at 9:40 am revealed: -The residents were served milk daily in the morning time during breakfast. -When residents were first admitted to the facility, they were asked their beverage preference for all meals.	D 299		

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-The residents' beverage preference was kept on a list in the kitchen that was developed and updated by the DM.
-When the residents beverage preference changed, they spoke with the DM.
-Milk and water were the only beverages offered on the menu.
-Milk was not offered daily because the residents became upset when asked their beverage preference repeatedly.
-She was aware that residents were to be served or offered milk twice daily.
-She was responsible for serving meals and beverages according to the menus.

Interview with the Resident Care Director (RCD) on 04/27/18 at 10:10 am revealed:
-The menus indicated the resident's beverage of choice and the residents were capable of requesting what they preferred to drink.
-Milk was served with cereal in the morning daily.

Interview with the Administrator on 04/27/18 at 4:30 pm revealed he referred all survey questions to the RCD.

2. Review of the resident roster (not dated) revealed the census in SCU was 13.

Review of the facility cycle 1 menus for the week of 04/22/18 through 04/28/18 on 04/26/18 revealed milk was listed on the menu for all three meals each day.

Observation of the breakfast meal service in the SCU dining room on 04/26/18 at 7:55 am revealed:
-There were 5 of 11 residents who were served milk in their cereal.
-No other residents were served or offered milk.

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D 299	Continued From page 20 Observation of the dinner meal service in the SCU dining room on 04/26/18 at 4:34 pm revealed no residents were served or offered milk during the dinner meal. Interview with a SCU medication aide (MA) on 04/26/18 at 4:30 pm revealed: -SCU residents were served milk during breakfast only if cereal was on the menu. -The SCU residents were not served or offered milk during lunch or dinner/supper. Interview with a Special Care Unit (SCU) resident on 04/26/18 at 2:30 pm revealed: -She was not offered or served milk unless she asked for milk. -She would like to be served milk with each meal. -Resident did not know that she could have milk with every meal. Interview with a resident on 04/26/18 at 3:00 pm revealed: -She usually was served water and tea with her meals. -She was not offered or served milk at meals; if milk was offered, she would take a cup. -She would like to be served milk with each meal. -She had not requested milk. Interview with a resident's family member on 04/26/18 at 2:45 pm revealed: -She visited during the lunch meal service, but she did not see milk being served. -She had not asked about how often residents were served milk. Interview with the Dietary Manager (DM) on 04/27/18 at 9:40 am revealed: -She did not know that SCU residents were to be	D 299		

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D 299	Continued From page 21 served milk twice daily. -Milk was transported from the kitchen refrigerator to the SCU refrigerator when the staff told her more was needed. -The DAs did not serve the milk in the SCU. -The SCU staff served the milk to SCU residents. -No instructions were given to the SCU staff about serving milk to SCU residents. Interview with the Resident Care Director (RCD) on 04/27/18 at 10:10 am revealed: -She was unsure how milk was served to residents in the SCU. -She had not observed milk being served to residents in the SCU. -She had only observed milk being served to residents in the AL. Interview with the Administrator on 04/25/18 at 9:45am and 04/27/18 at 4:30 pm revealed he referred all nursing and survey questions to the RCD.	D 299		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's	D 344		

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D 344	Continued From page 22 record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to clarify two orders (with the same dates) related to when to notify the resident's primary care physician (PCP) for finger stick blood sugar (FSBS) parameters for 1 of 5 sampled residents (#5). The findings are: Review of Resident #5's current FL-2 dated 02/27/18 revealed diagnoses included insulin dependent diabetes mellitus, high blood pressure with electrolyte imbalance, metabolic acidosis and metabolic encephalopathy. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 03/05/18. Review of Resident #5's physicians' orders dated 02/27/18 revealed finger stick blood sugars (FSBS) were to be taken at breakfast and lunch and Novolog (a rapid acting insulin used to lower blood sugars) was to be administered subcutaneous using a sliding scale with the following parameters: -If FSBS ranged from 180 to 229, give 2 units (u) of Novolog. -If FSBS ranged from 230 to 279, give 4 u of Novolog. -If FSBS ranged from 280 to 329, give 6 u of Novolog. -If FSBS ranged from 330 to 379, give 8 u of	D 344		

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D 344	Continued From page 23 Novolog. -If FSBS ranged from 380 to 429, give 10 u of Novolog. -If FSBS was greater than 430, give 12 u Novolog and call the resident's primary care physician (PCP). Review of Resident #5's subsequent physicians' orders dated 03/5/18 revealed: -There was an order to take the resident's FSBS at 7:30am, 4:30pm and at bedtime. -If the FSBS was less than 60, give the resident an Insta-Glucose gel (used to treat low blood sugars) and notify the resident's PCP. -If the FSBS was greater than 300 notify the resident's PCP. Review of Resident #5's subsequent physicians' orders dated 03/13/18 revealed FSBS were to be taken at breakfast and lunch and Novolog was to be administered subcutaneous using a sliding scale with the following parameters: -If FSBS ranged from 180 to 229, give 2 u of Novolog. -If FSBS ranged from 230 to 279, give 4 u of Novolog. -If FSBS ranged from 280 to 329, give 6 u of Novolog. -If FSBS ranged from 330 to 379, give 8 u of Novolog. -If FSBS ranged from 380 to 429, give 10 u of Novolog. -If FSBS was greater than 430, give 12 u Novolog and call the resident's PCP. -There was a second order to take the resident's FSBS at 7:30am, 4:30pm and at bedtime. If the FSBS was less than 60, give the resident an Insta-Glucose gel and notify the resident's PCP. If the FSBS was greater than 300 notify the resident's PCP.	D 344		

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D 344	Continued From page 24 Review of Resident #5's current physicians' orders dated 04/01/18 revealed FSBS were to be taken at breakfast and lunch and Novolog was to be administered subcutaneous using a sliding scale with the following parameters: -If FSBS ranged from 180 to 229, give 2 u of Novolog. -If FSBS ranged from 230 to 279, give 4 u of Novolog. -If FSBS ranged from 280 to 329, give 6 u of Novolog. -If FSBS ranged from 330 to 379, give 8 u of Novolog. -If FSBS ranged from 380 to 429, give 10 u of Novolog. -If FSBS was greater than 430, give 12 u Novolog and call the resident's PCP. -There was a second order to take the resident's FSBS at 7:30am, 4:30pm and at bedtime. If the FSBS was less than 60, give the resident an Insta-Glucose gel and notify the resident's PCP. If the FSBS was greater than 300 notify the resident's PCP. Review of Resident #5's March 2018 Electronic Medication Administration Record (eMAR) revealed: -Check and record blood sugar twice daily; before breakfast (7:30am) and dinner (4:30pm) and inject Novolog insulin per sliding scale (If FSBS ranged from 180 to 229, give 2 u; from 230 to 279, give 4 u; from 280 to 329, give 6 u; from 330 to 379, give 8 u; from 380 to 429, give 10 u; greater than 430, give 12 u Novolog and call the resident's PCP) was dated and transcribed on the eMAR 03/05/18 as the original date. -On twelve of fifty four opportunities, the FSBS was greater than 430. -At 7:30am, from 03/06/18 to 03/31/18, FSBS	D 344		

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ranged from 141 to 370.
-At 4:30pm, from 03/06/18 to 03/31/18, FSBS ranged from 234 to 555.
-A second entry to check and record FSBS three times daily (7:30am, 4:30pm, and 8:00pm); if FSBS was less than 60, give Insta-Glucose gel; notify the resident's PCP if FSBS was less than 60 or greater than 300 was dated and transcribed on the eMAR 03/05/18 as the original date.
-On fifty of seventy eight opportunities, the FSBS was greater than 300.
-At 7:30am, from 03/06/18 to 03/31/18, the FSBS ranged from 141 to 370.
-At 4:30pm, from 03/06/18 to 03/31/18, the FSBS ranged from 234 to 555.
-At 8:00pm, from 03/06/18 to 03/31/18, the FSBS ranged from 166 to 530.
-On 03/29/18 at 8:00pm, there was an entry with an initial circled, which indicated the resident was out of the facility.
-The resident's PCP was contacted on 03/14/18 at 5:01pm, when the resident's FSBS was 520.
-The sliding scale insulin was documented as administered correctly to the resident on 03/14/18.
-There was no other documentation on the eMAR, when the resident's PCP was contacted for elevated FSBS.

Review of Resident #5's April 2018 eMAR revealed:
-Check and record blood sugar twice daily; before breakfast (7:30am) and dinner (4:30pm)and inject Novolog insulin per sliding scale (If FSBS ranged from 180 to 229, give 2 u; from 230 to 279, give 4 u; from 280 to 329, give 6 u; from 330 to 379, give 8 u; from 380 to 429, give 10 u; greater than 430, give 12 u Novolog and call the resident's PCP dated and transcribed on the eMAR 03/05/18 as the original date.

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D 344	Continued From page 26 -On five of fifty five opportunities, the FSBS was greater than 430. -At 7:30am, from 04/01/18 to 04/27/18, FSBS ranged from 72 to 210. -At 4:30pm, from 04/01/18 to 04/26/18, FSBS ranged from 151 to 552. -A second entry to check and record FSBS three times daily (7:30am, 4:30pm, and 8:00pm); if FSBS was less than 60, give Insta-Glucose gel; notify the resident's PCP if FSBS was less than 60 or greater than 300 was dated and transcribed on the eMAR 03/05/18 as the original date. -On twenty nine of seventy eight opportunities, the FSBS was greater than 300. -At 7:30 am, from 04/01/18 to 04/27/18, FSBS ranged from 72 to 210. -At 4:30pm, from 04/01/18 to 04/26/18, FSBS ranged from 151 to 552. -At 8:00pm, from 04/01/18 to 04/26/18, FSBS ranged from 193 to 410. -There was no documentation on the eMAR when the resident's PCP was contacted for elevated FSBS. Review of Resident #5's progress notes and faxed sheets revealed: -The PCP was contacted on 03/09/18, when he resident's FSBS was 479 at 4:30pm; on 03/10/18, when FSBS was 409 at 4:30pm; on 03/15/18, when FSBS was 463 at 4:30pm; on 03/15/18, when FSBS was 530 at 7:30pm; on 03/17/18, when FSBS was 475 at 4:30pm; on 03/17/18, when FSBS was 500 at 7:30pm; on 03/20/18, when FSBS was 420 at 8:00pm; on 03/22/18, when FSBS was 442 at 8:00pm; on 03/23/18, when FSBS was 555 at 5:00pm; on 03/25/18, when FSBS was 498 at 4:30pm; on 03/25/18, when FSBS was 474 at 7:30pm; on 03/26/18, when FSBS was 541 at 4:30pm; on 03/26/18, when FSBS was 444 at 7:30pm; on 03/29/18,	D 344		

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	HAL039009	A. BUILDING: _____ B. WING _____	04/27/2018

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when FSBS was 446 at 4:00pm; on 03/31/18, when FSBS was 537 at 4:30pm; on 04/03/18, when FSBS was 445 at 7:30pm; on 04/05/18, when FSBS was 552 at 4:30pm; on 04/05/18, when FSBS was 402 at 7:30pm; on 04/18/18, when FSBS was 316 at 7:30pm.
-The sliding scale insulin was not documented as administered to the resident correctly on 03/09/18 at 4:30pm, on 03/10/18 at 4:30pm and on 03/26/18 at 4:30pm.

Interview with medication aide (MA) on 04/26/18 at 5:27pm revealed:
-She administered medications to Resident #5.
-She followed the eMAR to determine when to check Resident #5's FSBS.
-When she took Resident #5's FSBS, it was never at a range where she needed to notify the resident's PCP.
-She had not contacted the PCP to clarify orders for Resident #5's blood sugar monitoring nor the insulin order.
-She did not know there were two FSBS parameter orders.
-She was unsure of which order to use related to when to notify Resident #5's PCP for the FSBS level.
-She would have to discuss the orders with the Resident Care Director (RCD).

Interview with a second MA on 04/27/18 at 9:05am revealed:
-She was a MA and worked first shift.
-Resident #5's FSBS was taken twice daily.
-If Resident #5's FSBS sugars were within a certain range, the resident received insulin.
-If Resident #5's FSBS was less than 60 or greater than 400, she contacted the resident's PCP.
-She had been following that FSBS level, since

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the resident had been at the facility (03/05/18).
-She was not aware of any other orders related to when to notify Resident #5's PCP for FSBS levels.

Interview with a third MA on 04/27/18 at 11:08am revealed:
-Resident #5 had an order for FSBS and to administer Novolog insulin to the resident when the FSBS was a certain range.
-She followed the resident's eMAR related to when to contact Resident #5's PCP for the FSBS level.
-She contacted Resident #5's PCP if the FSBS was greater than 430.
-There was no order to contact the resident's PCP if the FSBS was greater than 300.
-If a resident had 2 different orders when to contact the PCP, she would contact the RCD for clarifications.
-She had not contacted Resident #5's PCP to clarify orders, because she was not aware Resident #5 had two orders related to when to contact the PCP.

Telephone interview with a medical assistant at Resident #5's PCP's office on 04/27/18 at 2:20pm revealed:
-Resident #5 had an order dated 03/06/18 and 04/10/18 to check FSBS before breakfast (7:30am) and dinner (4:30pm)and inject Novolog insulin per sliding scale (If FSBS ranged from 180 to 229, give 2 u; from 230 to 279, give 4 u; from 280 to 329, give 6 u; from 330-379, give 8 u; from 380 to 429, give 10 u; greater than 430, give 12 u Novolog and call the PCP).
-The resident had a second order dated 03/06/18 and 04/10/18 to check FSBS at 7:30am, 4:30pm and at bedtime.
-If the FSBS was less than 60, give the resident

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D 344	Continued From page 29 an Insta-Glucose gel and notify the PCP. -If the FSBS was greater than 300 notify the PCP. -She did not know which FSBS level for Resident #5 the PCP wanted to be notified. -She did not see any other orders in the resident's record. Interview with the RCD on 04/27/18 at 8:51 am revealed: -She did not realize there was two orders for Resident #5 related to when when to notify the PCP of the resident's FSBS level, until a MA told her on the night of 04/27/18. -The facility received a verbal order for Resident #5 the night of 04/26/18 to contact the resident's PCP if the FSBS was less than 60 or greater than 500. A second interview with the RCD on 04/27/18 at 4:48pm revealed: -When she received an order for a resident, she faxed the order to the resident's pharmacist and transcribed the order on the eMAR. -She checked resident records monthly to make sure orders were implemented. -If she had known there were two orders on when to notify Resident #5's PCP, she would have clarified the orders. -She last checked the residents' charts to make sure the orders were clear and implemented at the end of March 2018. -She could not remember when she last checked Resident #5's record. Interview with the Administrator on 04/25/18 at 9:45am and 04/27/18 at 4:30pm revealed he referred all nursing and survey questions to the RCD. The failure of the facility to clarify orders on when	D 344		

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D 344	Continued From page 30 to notify the resident's primary care physician for finger stick blood sugar parameters for Resident #5, resulting in 17 of 109 opportunities the blood sugars was greater than 430 and 79 of 156 opportunities the blood sugars was greater than 300. This failure was detrimental to the health, safety and welfare to the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/27/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 11, 2018	D 344		
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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure Novolog insulin was administered as ordered by a licensed	D 358		

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D 358	Continued From page 31 prescribing for 1 of 2 sampled residents (#5) with orders for sliding scale. The findings are: Review of Resident #5's current FL-2 dated 02/27/18 revealed diagnoses included insulin dependent diabetes mellitus, high blood pressure with electrolyte imbalance, metabolic acidosis and metabolic encephalopathy. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 03/05/18. Review of Resident #5's current and subsequent physician's orders dated 02/27/18, 03/13/18 and 04/01/18 revealed FSBS were to be taken at breakfast and lunch and Novolog (a rapid acting insulin used to help lower blood sugars) was to be administered subcutaneous using a sliding scale with the following parameters: -If FSBS ranged from 180 to 229, give 2 units (u) of Novolog. -If FSBS ranged from 230 to 279, give 4 u of Novolog. -If FSBS ranged from 280 to 329, give 6 u of Novolog. -If FSBS ranged from 330 to 379, give 8 u of Novolog. -If FSBS ranged from 380 to 429, give 10 u of Novolog. -If FSBS was greater than 430, give 12 u Novolog and call the resident's primary care physician (PCP). Review of Resident #5's current and subsequent physician's orders dated 03/05/18, 03/13/18 and 04/01/18 revealed: -There was a second order to take the resident's	D 358		

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FSBS at 7:30am, 4:30pm and at bedtime.
-If the FSBS was less than 60, give the resident an Insta-Glucose gel and notify the resident's PCP (used to help treat low blood sugars.)
-If the FSBS was greater than 300 notify the resident's PCP.

Review of Resident #5's March 2018 Electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check and record blood sugar twice daily; before breakfast (7:30am) and dinner (4:30pm)and inject Novolog insulin per sliding scale (If FSBS ranged from 180 to 229, give 2 u; from 230 to 279, give 4 u; from 280 to 329, give 6 u; from 330 to 379, give 8 u; from 380 to 429, give 10 u; greater than 430, give 12 u Novolog and call the resident's PCP) was transcribed on the eMAR.
-At 7:30am from 03/06/18 to 03/31/18 FSBS ranged from 141 to 370.
-At 4:30pm from 03/06/18 to 03/31/18 FSBS ranged from 234 to 555.
-There were 8 of 52 opportunities Novolog insulin was not administered as ordered as follows:
-On 03/07/18 at 7:30am, the FSBS was 141; 2 u of insulin was documented as administered and the resident should not have received any units of insulin.
-On 03/09/18 at 7:30am, the FSBS was 165; 2 u of insulin was documented as administered and the resident should not have received any units of insulin.
-On 03/09/18 at 4:30pm, the FSBS was 479; 10 u of insulin was documented as administered and the resident should have received 12 u of insulin.
-On 03/16/18 at 7:30am, the FSBS was 309; 4 u of insulin was documented as administered and the resident should have received 6 u of insulin.
-On 03/26/18 at 4:30pm, the FSBS was 541; 10u

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of insulin was documented as administered and the resident should have received 12 u of insulin.
-On 03/10/18 at 4:30pm, the FSBS was 409; 12 u of insulin was documented as administered and the resident should have received 10 u of insulin.
-On 03/11/18 at 4:30pm, the FSBS was 379; 12 u of insulin was documented as administered and the resident should have received 8 u of insulin.
-On 03/12/18 at 4:30pm, the FSBS was 253; 8 u of insulin was documented as administered and the resident should have received 4 u of insulin.

Review of Resident #5's April 2018 eMAR revealed:
-There was an entry to check and record blood sugar twice daily; before breakfast (7:30am) and dinner (4:30pm)and inject Novolog insulin per sliding scale (If FSBS ranged from 180 to 229, give 2 u; from 230 to 279, give 4 u; from 280 to 329, give 6 u; from 330 to 379, give 8 u; from 380 to 429, give 10 u; greater than 430, give 12 u Novolog and call the resident's PCP was transcribed on the eMAR).
-At 7:30 am from 04/01/18 to 04/27/18 FSBS ranged from 72 to 210.
-At 4:30pm from 04/01/18 to 04/26/18 FSBS ranged from 151 to 552.
-There was 1 of 53 opportunities Novolog insulin was not administered as ordered.
-On 04/15/18 at 7:30am, the FSBS was 257; 8 u of insulin was documented as administered and the resident should have received 4 u of insulin.

Interview with Resident #5 on 04/26/18 at 4:36pm revealed:
-The residents FSBS was taken three times daily.
-The resident's blood sugars were low and high at times.
-The resident's blood sugars had reached to 500 at least once.

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D 358	Continued From page 34 -The medication aides (MA) gave the resident insulin when it was high. -When her blood sugar was high, staff never rechecked her blood sugars. -She did not know if the PCP was aware of the high blood sugars. -She had never gone to the hospital, because her blood sugars were too low or high. -When the resident's blood sugar had reached 500, she did not have any complaints of headaches, increased thirst, or weight loss. Interview with a MA on 04/27/18 at 9:05am revealed: -Resident #5's FSBS was taken twice daily. -If Resident #5's FSBS sugars were within a certain range, the resident received insulin. -When Resident #5 was first admitted the facility, the MA was new at using the sliding scale. -She checked Resident #5's FSBS on 03/07/18 at 7:30am and the FSBS was 141. She also checked the resident's FSBS on 03/09/18 at 4:30pm and the FSBS was 165. She administered 2 u of insulin to the resident after both readings. -The resident should not have received any insulin on those FSBS readings. -She gave the insulin to the resident, because she thought that was what she was supposed to do. -After she gave the resident the insulin each time, she reported what she did to the RCD. -The RCD told her she should not have administered insulin to the resident. Interview with a second MA on 04/27/18 at 11:08am revealed: -Resident #5 had an order for FSBS and to administer Novolog insulin to the resident when the FSBS was a certain range.	D 358		

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D 358	Continued From page 35 -She did not know if Resident #5 had ever gone to the hospital due to low or high blood sugars. -If she administered the incorrect amount of insulin to a resident, she contacted the RCD. Telephone interview with a medical assistant at Resident #5's primary care physician's (PCP's) office 04/27/18 at 2:20pm revealed: -Resident #5 had an order dated 03/06/18 and 04/10/18 to check FSBS before breakfast (7:30am) and dinner (4:30pm) and inject Novolog insulin per sliding scale (If FSBS ranged from 180 to 229, give 2 u; from 230 to 279, give 4 u; from 280 to 329, give 6 u; from 330-379, give 8 u; from 380 to 429, give 10 u; greater than 430, give 12 u Novolog and call the PCP). -The resident had a second order dated 03/06/18 and 04/10/18 to check FSBS at 7:30am, 4:30pm and at bedtime. -If the FSBS was less than 60, give the resident an Insta-glucose gel and notify the PCP. -If the FSBS was greater than 300 notify the PCP. -Resident #5 was non compliant with her diet and the PCP was aware. -There was no documentation the resident's PCP was aware of insulin administration errors by staff. -The PCP was not available for interview. Telephone interview with the contracted Pharmacist Supervisor at the local pharmacy on 04/27/18 at 3:00pm revealed: -The facility would not send the pharmacy a medication error report. -It would only be sent to the resident's PCP. -They did not have a report from the facility of a medication error for Resident #5. Telephone interview with the contracted Pharmacist on 04/27/18 at 4:29pm revealed:	D 358		

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D 358	Continued From page 36 -She was last at the facility on 04/18/18 and she completed the facility's quarterly pharmacy reviews. -She could not remember if Resident #5 had insulin errors with her sliding scale. Interview with the RCD on 04/27/18 at 4:48pm revealed: -She did not know about the insulin errors in March 2018 and April 2018 for Resident #5. -She did not realize insulin had been administered incorrectly to Resident #5 until 04/27/18. -She checked resident records monthly to make sure the insulin was administered as ordered. -She could not remember when she last checked Resident #5's record to make sure the resident's insulin was administered as ordered by the PCP. -When there was an insulin error, she completed a form and submitted it to the resident's PCP and local pharmacy. -She did not submit the form to the resident's PCP and the local pharmacy about the insulin administration error, because she did not realize there were errors. Attempted telephone interview on 04/27/18 at 4:22pm with Staff E, MA, who checked Resident #5's FSBS, documented and administered the incorrect amount of insulin to the resident on 03/09/18 at 4:30pm, 03/10/18 at 4:30pm, 03/11/18 at 4:40pm, 03/16/18 at 7:30am and on 03/26/18 at 4:30pm, was unsuccessful. Interview with the Administrator on 04/25/18 at 9:45am and 04/27/18 at 4:30pm revealed he referred all nursing and survey questions to the RCD. The facility failed to ensure Novolog sliding scale	D 358		

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D 358	Continued From page 37 was administered as ordered, resulting in insulin administration errors that could cause Resident #5 to become hypoglycemic or hyperglycemic, which was detrimental to the health, safety and welfare to a resident (#5) and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/27/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 11, 2018	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' 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 assure every resident had the right to receive care and services which were adequate, appropriate, and in compliance with relevant state laws and rules related to medication orders and medication administration. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to clarify two orders	D912		

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D912	Continued From page 38 (with the same dates) related to when to notify the resident's primary care physician (PCP) for finger stick blood sugar (FSBS) parameters for 1 of 5 sampled residents (#5). [Refer to Tag D 344 10A NCAC 13F .1002 Medication Orders (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure Novolog insulin was administered as ordered by a licensed prescribing for 1 of 2 sampled residents (#5) with orders for sliding scale. [Refer to Tag D 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		
D935	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	D935		

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	HAL039009	A. BUILDING: _____ B. WING _____	04/27/2018

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GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

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D935	Continued From page 39 exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 6 medication aides sampled (Staff C) completed the 5, 10 or 15 hour medication training or had verification of previous employment before administering medication to residents. The findings are: Review of Staff C's personnel file revealed: -Staff C was hired on 02/09/18 as a Medication Aide (MA). -Documentation Staff C completed a medication clinical skills validation on 02/21/18. -Documentation Staff C successfully passed the medication administration exam on 05/14/07.	D935		

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D935	Continued From page 40 -There was no documentation of a 5, 10 or 15 hour medication training on file. -There was no documentation of employment verification prior to beginning work as a MA at the facility. Interview on 04/27/18 at 4:07pm with Staff C (medication aide) revealed: -Staff C she had requested paperwork from her previous employer, including the 15-hour training certificate, but they had not released it. -She had passed the medication aide test in 2007. -She had worked continuously as a MA since passing her test in 2007. -She had taken the 15-hour training required for medication aides at her previous employer. -She had worked for her previous employer for over 8 years, until November 2017. Review of the March 2018 and April 2018 Medication Administration Records revealed Staff C had administered medications to the residents on a routine basis. Interview with Business Office Manager (BOM) on 04/27/18 at 2:34pm revealed: -She could not find an employment verification on file for Staff C. -She had contacted Staff C's previous employer to ask for verification, however she had not received it as of 04/27/18. -She kept the request for verification in the staff file until it was received; she did not have a copy of the request for verification for Staff C. -Sometimes she would fax the request 3-4 times, call the previous employer and sometimes they still would not respond. -She did not notify the Administrator if she had not received the employment verification, as the	D935		

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D935	Continued From page 41 Administrator had told her to document her attempts. -She knew each MA was supposed to have the verification on file. Interview with the Resident Care Director on 04/27/18 at 2:54pm revealed: -The BOM was responsible for requesting employment verification for all medication aides. -She verified the medication aides had passed the MA test. -She made sure before medication aides passed medications that they had passed the MA test and had been checked off on the medication clinical skills checklist. -MA's would not get checked off if they were not competent to pass medications. -She was responsible for assigning online training for all new medication aides that included the 5 and 10 hour training. -She did not know why she had not assigned the 5 and 10 hour training for Staff C, "I just forgot." -Staff C would be assigned the 5 and 10 hour training. Interview with the Administrator on 04/25/18 at 9:45am and 04/27/18 at 4:30pm revealed he referred all nursing and survey questions to the Resident Care Director (RCD).	D935		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is	D992		

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D992	Continued From page 42 conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure a screening for the presence of controlled substances was completed for 1 of 6 sampled staff (E), medication aide, prior to the date of hire. The findings are:	D992		

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D992	Continued From page 43 Review of the personnel file of Staff E on 04/27/18 revealed: -There was a hire date of 06/13/16. -There was a signed job description for a medication aide (MA)/personal care aide (PCA). -There was no documentation of a completed drug screen prior to employment. Observations of Staff E on 04/27/18 at 4:00 pm revealed: -Staff E was working during the second shift. -Staff E administered oral medications to the residents. Observations of Staff E on 04/27/18 at 4:30 pm revealed Resident Care Director (RCD) sent Staff E home to obtain documenation of 80 hours of PCA. Observations of Staff E on 4/27/18 at 5:00 pm revealed: -Staff E returned to the faciity at an unknown time. -Staff E was passing out medications to residents but was not available for an interview by the end of survey at 6:00 pm. Interview with the Business Office Manager (BOM) on 04/27/18 at 2:30 pm revealed: -The forms and the personnel files were maintained and managed by her. -She had new hires come back to the facility after the criminal background check to complete the drug screen. -Staff were notified by her, after the results of the drug screen were obtained, concerning hiring status. -Staff E was hired as a MA/PCA. -Staff E had resigned from the facility and was rehired more than once.	D992		

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D992	Continued From page 44 -She did not know the dates that Staff E resigned nor the dates of rehire. -Staff E's drug screen was not done because she thought Staff E had completed one already. -She was not aware that another drug screen had to be done upon rehire for Staff E. -Staff E's drug screen was not done because "it fell through the cracks". -She was responsible for ensuring the drug screens were completed. -The facility did not have a process for auditing the personnel files. Interview with the RCD on 04/27/18 at 3:17 pm revealed: -The BOM gave new employees the appropriate paperwork to complete for employment at the facility. -She was responsible for tuberculosis test arrangement, and configuring new employees in the computer for training. -She was not aware that Staff E had not completed a drug screen prior to hiring. -The BOM was responsible for ensuring drug screens were completed. -The facility did not have a system in place to audit the personnel files. Interview with the Administrator on 04/25/18 at 9:45 am and 04/27/18 at 4:30 pm revealed he referred all nursing and survey questions to the RCD.	D992		