STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL026031	A. BUILDING: _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL GROUP HOME	3510 CAMDEN ROAD FAYETTEVILLE, NC 28306

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/31/18.	C 000		
C 172	10A NCAC 13G .0504 (b) Competency Validation For Licensed Health Pro 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Task (b) Competency validation shall be performed by the following licensed health professionals: (1) A registered nurse shall validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(1) through (28) of Rule .0903 of this Subchapter. (2) In lieu of a registered nurse, a respiratory care practitioner licensed under G.S. 90, Article 38, may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (11), (16), (18), (19) and (21) of Rule .0903 of this Subchapter. (3) In lieu of a registered nurse, a registered pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(8) of Rule .0903 of this Subchapter (4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (27) of Rule .0903 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 of 3 sampled staff (Staff B) who worked in the home had been	C 172		

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C 172	Continued From page 1	C 172		

competency validated by a licensed health professional to perform fingerstick blood sugar checks.

The findings are:

Review of Staff B's personnel record revealed:
-Staff B was hired as a supervisor in charge/medication aide (SIC/MA) on 10/04/17.
-There was no Licensed Health Personnel Support (LHPS) skills checklist completed by a licensed health professional.

Review of a resident's August, September and October 2018 Medication Administration Records (MARs) revealed:
-There was documentation that Staff B checked the resident's fingerstick blood sugar (FSBS) 26 times in August 2018.
-There was documentation that Staff B checked the resident's FSBS 25 times in September 2018.
-There was documentation that Staff B checked the resident's FSBS 29 times in October 2018.

Interview with a resident on 10/31/18 at 2:15 pm revealed the resident depended on the facility staff to perform FSBS and administer medication.

Interview on 10/31/18 at 2:00 pm with Staff B revealed:
-She performed FSBS and administered insulin as ordered for a resident.
-She thought she had completed the LHPS skills validation with the registered nurse.
-A copy of the LHPS skills validation should be in her personnel record.

Interview with the Administrator on 10/31/18 at 2:35 pm revealed:
-He and the other Administrator were responsible

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C 172	Continued From page 2 for maintaining the personnel records, but the SIC was also familiar with the requirements for the personnel records. -He was not aware the required training was not in Staff B's personnel record. -Staff B would not perform any more FSBSs until her skills were validated by the registered nurse. -He would get the required training completed as soon as he could contact the registered nurse who performed training for the facility.	C 172		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family 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 record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure physician clarification for 1 of 3 sampled residents (Resident #1), related to orders for fingerstick blood sugars (FSBS) and insulin administration. The findings are:	C 315		

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C 315	Continued From page 3 Review of Resident #1's current FL2 dated 05/29/18 revealed: -Diagnoses included diabetes, dementia, hypertension and cardio dysrhythmia. -A physician's order for Novolog (a quick acting insulin) 6 units at lunch and supper. -A physician's order for Levemir (a slower acting insulin) 8 units at bedtime. -There was no order for FSBS. Interview with a representative from the physician's office on 10/31/18 at 10:45 am revealed: -Resident #1 had a physician's order for Novolog insulin 6 units at lunch and dinner daily, dated 02/17/18. -Resident #1 had a physician's order for FSBS three times daily (TID), dated 08/27/17. -Resident #1 had a physician's order for Levemir insulin 8 units at bedtime daily, dated 08/27/18. -Resident #1 did not have an order for sliding scale (SS) insulin. Interview with a pharmacy representative on 10/31/18 at 11:00 am revealed: -Resident #1 had a physician's order for Levemir insulin 8 units at bedtime daily, dated 08/27/18. -Resident #1 had an order for Novolog SS insulin to be given 3 times daily as follows: 201 - 240 = 2 units, 241 - 280 = 4 units, 281 - 320 = 6 units, 321 - 360 = 8 units, 361 - 400 = 10 units, 401 - 450 = 12 units, call MD if > 451. -She was unable to locate the original date of the SS order, but she determined the order began in 2014 and had been "refilled" annually. Observation of medication on hand for Resident #1 revealed both Novolog and Levemire insulin were available for administration.	C 315		

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C 315	Continued From page 4 Review of Resident #1's physician's orders revealed no documentation of order clarification for insulin administration or FSBS. Review of Resident #1's August, September and October 2018 Medication Administration Records (MARs) revealed: -There was an entry for Novolog inject 6 units subcutaneously at lunch and supper. -There was an entry for Levemir inject 8 units subcutaneously at bedtime. -There was an entry for Novolog SS insulin to be given 3 times daily at 8:00 am, 12:00 pm and 5:00 pm as follows: 201 - 240 = 2 units, 241 - 280 = 4 units, 281 - 320 = 6 units, 321 - 360 = 8 units, 361 - 400 = 10 units, 401 - 450 = 12 units, call MD if > 451. -There was an entry to check blood sugar 3 times daily. Review of Resident #1's "Accucheck Insulin Report" for August, September and October 2018 revealed: -Novalog was documented as administered 115 times from 08/01/18 through 10/31/18. -FSBS were checked 4 times each day. Interview on 10/31/18 at 10:10 am with a Medication Aide (MA) revealed: -Staff recorded the FSBS results and the amount of insulin administered on the "Accucheck Insulin Report". -Resident #1 did not receive the Novolog 6 units as ordered at lunch and supper, because she also had a SS insulin ordered. -If Resident #1 received both the SS insulin and the 6 units as ordered, "it would be too much". -She had not contacted the physician for clarification of the FSBS or the insulin orders.	C 315		

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C 315	Continued From page 5 Interview with Resident #1 on 10/31/18 at 2:15 pm revealed the resident depended on the facility staff to provide her medication as ordered by her physician. Interview with the Administrator on 10/31/18 at 12:00 pm revealed: -Resident #1 had FSBS and insulin ordered "several times a day". -The staff followed the orders from the physician for FSBS and insulin administration. -Any MA on duty would contact the physician for clarification of orders if needed. -He had not contacted Resident #1's physician for clarification of the insulin or FSBS orders.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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, record reviews and interviews, the facility failed to administer insulin and perform finger stick blood sugars as ordered by a licensed prescriber for 1 of 3 sampled residents (Resident #1). Review of Resident #1's current FL2 dated	C 330		

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C 330	Continued From page 6 05/29/18 revealed diagnoses included diabetes, dementia, hypertension and cardio dysrhythmia. Review of Resident #1's August, September and October 2018 Medication Administration Records (MARs) revealed: -There was an entry for Novolog (a quick acting insulin) inject 6 units subcutaneously at lunch and supper. -There was an entry for Levemir (a long acting insulin) inject 8 units subcutaneously at bedtime. -There was an entry for Novolog sliding scale (SS) insulin to be given 3 times daily at 8:00 am, 12:00 pm and 5:00 pm as follows: 201 - 240 = 2 units, 241 - 280 = 4 units, 281 - 320 = 6 units, 321 - 360 = 8 units, 361 - 400 = 10 units, 401 - 450 = 12 units, call MD if > 451. -There was an entry to check blood sugar 3 times daily. 1. Review of Resident #1's current FL2 dated 05/29/18 revealed a physician's order for Novolog 6 units at lunch and supper. Interview with a representative from the physician's office on 10/31/18 at 10:45 am revealed Resident #1 had a physician's order for Novolog 6 units to be given daily at lunch and supper, dated 02/17/18. Interview with a pharmacy representative on 10/31/18 at 11:00 am revealed Resident #1 had a physician's order for Novolog 6 units to be given daily at lunch and supper, dated 02/17/18. Interview on 10/31/18 at 10:10 am with a Medication Aide (MA) on duty revealed: -The MA on duty was responsible for contacting the pharmacy and documenting any new orders on the MAR.	C 330		

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C 330	Continued From page 7 -Resident #1 did not receive the Novolog 6 units as ordered at lunch and supper, because she also had a SS insulin ordered. -If Resident #1 received both the SS insulin and the 6 units as ordered, "it would be too much". -Staff documented FSBS results and insulin administration on the "Accucheck Insulin Report" monthly, instead of the MARs, because there was limited apace on the MARs. Review of Resident #1's "Accucheck Insulin Report" for August 2018 revealed: -Entries for FSBS ranged from 108 - 427. -There was no Novolog documented as administered on 08/23/18, 08/26/18, 08/29/18 or 08/30/18. -Novolog 2 units was documented as administered on 08/08/18, 08/14/18 and 08/25/18 at lunch time. -Novolog 6 units was documented as administered on 08/01/18, 08/02/18, 08/03/18, 08/04/18, 08/05/18, 08/10/18, 08/11/18, 08/16/18, 08/17/18, 08/22/18 and 08/28/18 at lunch time. -There was Novolog 0 units documented as administered on 08/06/18, 08/08/18, 08/09/18, 08/12/18, 08/13/18, 08/15/18, 08/18/18, 08/19/18, 08/20/18, 08/21/18, 08/24/18, 08/27/18 or 08/31/18 at lunch time. -There was no Novolog documented as administered on 08/01/18, 08/07/18, 08/09/18, 08/16/18, 08/20/18, 08/25/18 or 08/28/18 at supper. -Novolog 6 units was documented as administered on 08/02/18, 08/03/18, 08/04/18, 08/05/18, 08/06/18, 08/08/18, 08/10/18, 08/11/18, 08/12/18, 08/13/18, 08/14/18, 08/15/18, 08/18/18, 08/19/19, 08/21/18, 08/22/1808/23/18, 08/24/18, 08/26/18, 08/27/18, 08/29/18, 08/30/18, and 08/31/18 at supper time. -Novolog 0 units was documented as	C 330		

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C 330	Continued From page 8 administered on 08/17/18 at supper time. Review of Resident #1's "Accucheck Insulin Report" for September 2018 revealed: -Entries for FSBS ranged from 77 - 449. -There was no Novolog documented as administered on 09/01/18, 09/03/18, 09/04/18, 09/14/18, 09/15/18, 09/19/18, 09/20/18, 09/26/18/, 09/29/18, or 09/30/18 at lunch time. -Novolog 2 units was documented as administered on 09/13/18 at lunch time. -Novolog 4 units was documented as administered on 09/06/18 and 09/17/18 at lunch time. -Novolog 6 units was dcoumented as administered on 09/05/18, 09/09/18, 09/10/18, 09/16/18, 09/21/18, 09/22/18, 09/17/18 and 09/28/19 at lunch time. -Novalog 0 units was documented as administered on 09/02/18, 09/08/18, 09/11/18, 09/12/18, 09/18/18, 09/23/18, 09/24/18 and 09/25/18 at lunch time. -There was no Novolog documented as administered on 09/01/18, 09/02/18, 09/07/18, 09/08/18, 09/09/18, 09/13/18, 09/14/18 or 09/15/18 at supper time. -Novolog 6 units was documented as administered on 09/04/18, 09/05/18, 09/06/18, 09/10/18, 09/11/18, 09/12/18, 09/17/18, 09/18/18, 09/19/18, 09/20/18, 09/21/18, 09/22/18, 09/23/18, 09/24/18, 09/25/18, 09/26/18, 09/27/18, 09/28/18, 09/29/18 and 09/30/18 at supper time. Review of Resident #1's "Accucheck Insulin Report" for October 2018 revealed: -Entries for FSBS ranged from 76 - 395. -Novolog 6 units was documented as administered on 10/03/18, 10/07/18, 10/09/18, 10/10/18, 10/15/18 and 10/21/18 at lunch time. -Novalog 0 units was documented as	C 330		

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C 330	Continued From page 9	C 330		

administered on 10/01/18, 10/02/18, 10/04/18, 10/06/18, 10/11/18, 10/12/18, 10/13/18, 10/18/18, 10/19/18, 10/20/18, 10/23/18, 10/24/18, 10/25/18, 10/26/18, 10/29/18 and 10/30/18 at lunch time.
-There was no Novolog documented as administered on 10/05/18, 10/08/18, 10/14/18, 10/16/18, 10/17/18, 10/22/18, 10/27/18 or 10/28/18 at lunch time.
-Novolog 2 units was documented as administered on 10/19/18 at supper time.
-Novolog 6 units was dcoumented as administered on 10/02/18, 10/03/18, 10/05/18, 10/06/18, 10/07/18, 10/08/18, 10/09/18, 10/10/18, 10/11/18, 10/12/18, 10/13/18, 10/14/18, 10/15/18, 10/16/18, 10/17/18, 10/18/18, 10/20/18, 10/21/18, 10/22/18, 10/23/18, 10/24/18, 10/25/18, 10/26/18, and 10/29/18 at supper time.
-There was no Novalog documented as administered on 10/01/18, 10/04/18, 10/27/18, 10/28/18 or 10/30/18 at supper time.

Observation of medication on hand for Resident #1 revealed Novolog insulin was available for administration.

Refer to interview with Resident #1 on 10/31/18 at 2:15 pm.

Refer to interview with the Administrator on 10/31/18 at 12:00 pm.

2. Review of Resident #1's current FL2 dated 05/29/18 revealed a physician's order for Levemir 8 units daily at bedtime.

Interview with a representative from the physician's office on 10/31/18 at 10:45 am revealed:
-Resident #1 had a physician's order for Levemir insulin 8 units at bedtime daily, dated 08/27/18.

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C 330	Continued From page 10 Interview with a pharmacy representative on 10/31/18 at 11:00 am revealed: -Resident #1 had a physician's order for Levemir insulin 8 units at bedtime daily, dated 08/27/18. Interview on 10/31/18 at 10:10 am with a Medication Aide (MA) on duty revealed resident #1 received Levemir 8 units daily at bedtime. Review of Resident #1's "Accucheck Insulin Report" for August 2018 revealed: -Levemir 8 units was documented as administered on 08/02/18, 08/08/18, 08/06/18, 08/08/18, 08/10/18, 08/11/18, 08/12/18, 08/14/18, 08/15/18, 08/19/18, 08/21/18, 08/22/18, 08/23/18, 08/26/18, 08/27/18, 08/29/18, 08/30/18 and 08/31/18. -There was no Levemir documented as administered on 08/01/18, 08/03/18, 08/04/18, 08/07/18, 08/09/18, 08/16/18, 08/17/18, 08/20/18, 08/25/18 or 08/28/18 at bedtime. Review of Resident #1's "Accucheck Insulin Report" for September 2018 revealed: -Levemir 8 units was documented as administered on 09/03/18, 09/04/18, 09/06/18, 09/09/18, 09/10/18, 09/11/18, 09/12/18, 09/14/18, 09/15/18, 09/16/18, 09/17/18, 09/18/18, 09/20/18, 09/21/18, 09/23/18, 09/24/18, 09/25/18, 09/26/18, 09/27/18, 09/28/18, 09/29/18 and 09/30/18 at bedtime. -There was no Levemir documented as administered on 09/01/18, 09/02/18, 09/05/18, 09/07/18, 09/08/18, 09/13/18 or 09/22/18 at bedtime. Review of Resident #1's "Accucheck Insulin Report" for October 2018 revealed: -Levemir 8 units was documented as	C 330		

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C 330	Continued From page 11	C 330		

administered from 10/03/18/18 through 10/26/18 and 10/29/18 at bedtime.
-There was no Levemir documented as administered on 10/01/18, 10/02/18, 10/27/18, 10/28/18 or 10/30/18 at bedtime.

Observation of medication on hand for Resident #1 revealed Levemire insulin was available for administration.

Refer to interview with Resident #1 on 10/31/18 at 2:15 pm.

Refer to interview with the Administrator on 10/31/18 at 12:00 pm.

3. Review of Resident #1's current FL2 dated 05/29/18 revealed no order for Sliding Scale (SS) insulin.

Interview with a representative from the physician's office on 10/31/18 at 10:45 am revealed:
-Resident # 1 did not have an order for sliding scale (SS) insulin.

Interview with a pharmacy representative on 10/31/18 at 11:00 am revealed:
-Resident #1 had an order for Novolog SS insulin to be given 3 times daily as follows: 201 - 240 = 2 units, 241 - 280 = 4 units, 281 - 320 = 6 units, 321 - 360 = 8 units, 361 - 400 = 10 units, 401 - 450 = 12 units, call MD if > 451.
-She was unable to locate the original date of the SS order, but she determined the order began in 2014 and had been "refilled" annually ever since.

Interview on 10/31/18 at 10:10 am with a Medication Aide (MA) on duty revealed:
-Resident #1 had a SS insulin ordered three

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	FCL026031	A. BUILDING: _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL GROUP HOME	3510 CAMDEN ROAD FAYETTEVILLE, NC 28306

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C 330	Continued From page 12 times daily, at breakfast, lunch and supper time. Review of Resident #1's "Accucheck Insulin Report" for August, September and October 2018 revealed FSBS were documented 4 times daily, at breakfast, lunch, supper and bedtime. Observation of medication on hand for Resident #1 revealed Novolog insulin was available for administration. Refer to interview with Resident #1 on 10/31/18 at 2:15 pm. Refer to interview with the Administrator on 10/31/18 at 12:00 pm. Interview with Resident #1 on 10/31/18 at 2:15 pm revealed the resident depended on the facility staff to obtain the FSBS results and administer the insulin. Interview with the Administrator on 10/31/18 at 12:00 pm revealed: -Resident #1 had FSBS and insulin ordered "several times a day". -The staff followed the orders from the physician for FSBS and insulin administration. The facility failed to administer insulin and obtain fingerstick blood sugars as ordered to Resident #1. This failure placed the resident at risk for hypoglycemia and hyperglycemia, which was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/31/18 for this violation.	C 330		

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C 330	Continued From page 13 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2018	C 330		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration and infection prevention requirements. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to administer insulin and perform finger stick blood sugars as ordered by a licensed prescriber for 1 of 3 sampled residents (Resident #1) [Refer to Tag 330, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on record reviews and interviews the facility failed to assure 2 of 3 sampled medication aides (Staff A and Staff B) annually completed the state mandated infection control course [Refer to Tag 934, G.S. 131D 4.5B(a) Adult Care Homes Medication Aides (Type B Violation)].	C 912		

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C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 2 of 3 sampled medication aides (Staff A and Staff B) completed the annual state mandated infection control course. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired as a Supervisor In Charge (SIC)/Medication Aide (MA) on 06/29/14. -There was documentation of completion of the annual infection control course on 09/09/14. -There was no additional documentation of annual training on the state mandated infection control course.	C 934		

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C 934	Continued From page 15 Review of a resident's August, September and October 2018 "Accucheck Insulin Report" revealed Staff A documented FSBS and insulin administration on 105 of 294 opportunities. Interview with Staff A on 10/31/18 at 9:00 am revealed: -She worked at the facility on the split shift, usually from 6:00 am to 2:00 pm or from 2:00 pm to 10:00 pm. -She cooked meals, checked vital signs, assisted residents with showers and baths, assisted residents with dressing and transfers, administered medications, including insulin injections and performed fingerstick blood sugars. Refer to interview with the Administrator on 10/31/18 at 2:35 pm. 2. Review of Staff B's personnel record revealed: -Staff B was hired as a Supervisor In Charge (SIC)/Medication Aide (MA) on 10/04/17. -There was no documentation of completion of the annual infection control course. Review of a resident's August, September and October 2018 "Accucheck Insulin Report" revealed Staff B performed and documented FSBS and insulin administration on 79 of 294 opportunities. Interview on 10/31/18 at 2:00 pm with Staff B revealed: -She did not remember if she had completed the annual infection control course, but she had completed bloodborne pathogens training in the past. -A copy of the completed infection control course should be in her personnel record.	C 934		

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C 934	Continued From page 16 Refer to interview with the Administrator on 10/31/18 at 2:35 pm. _____ Interview with the Administrator on 10/31/18 at 2:35 pm revealed: -He and a family member (also the Administrator) were responsible for maintaining the personnel records, but the SIC was also familiar with the records. -He was not aware the required training was not in the personnel records. -He would get the required training completed as soon as he could contact the nurse who performed training for the facility. _____ The facility failed to assure mandatory, annual state approved infection control training for 2 of 3 sampled medication aides. This failure placed the residents at risk for infection while blood glucose was monitored. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/31/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2018	C 934		
C937	G.S. 131D-4.3 (a) ACH Training for Personal Care Aides G.S. 131D-4.3 (a) Adult care home training for personal care aides (2) A minimum of 80 hours of training for personal care aides. The training for aides shall	C937		

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C937	Continued From page 17 be comparable to State-approved Certified Nurse Aide I training. The facility may exempt from the 80-hour training requirement any personal care aides who are or have been either licensed as a health care professional or listed on the Nurse Aide Registry. (3) Monitoring and supervision of residents. (4) Oversight and quality of care as stated in G.S. 131D-4.1. (5) Adult care homes shall comply with all of the following staffing requirements: a. First shift (morning): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents (licensed capacity or resident census) plus 3.0 hours for all other residents, whichever is greater; b. Second shift (afternoon): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents plus 3.0 hours for all other residents (licensed capacity or resident census), whichever is greater; c. Third shift (evening): 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). The facility shall provide staff to meet the needs of the facility's residents. Each facility shall post in a conspicuous place information about required staffing that enables residents and their families to ascertain each day the number of direct care staff and supervisors that are required by law to be on duty for each shift for that day. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had successfully completed an 80 hour personal care training program and competency evaluation.	C937		

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C937	Continued From page 18 The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 06/29/14 as a Supervisor in Charge (SIC)/Medication Aide (MA). -She was not listed on the Nurse Aide Registry. -There was no documentation Staff A had completed an 80 hour personal care training program and competency evaluation. Interview with Staff A on 10/31/18 at 9:00 am revealed: -She worked at the facility on the split shift, usually from 6:00 am to 2:00 pm or from 2:00 pm to 10:00 pm. -She cooked meals, assisted residents with showers and baths, assisted residents with dressing and transfers, administered medications and performed fingerstick blood sugars. -She also performed vitals on residents as ordered by the physician. Observation of Staff A on 10/31/18 at 8:15 revealed: -She provided assistance to a resident by propelling her in wheelchair to the dining area. -She provided assistance to the same resident by propelling her in a wheelchair to the living room after breakfast was completed. -She performed the blood pressure check of another resident. -Interview with the Administrator on 10/31/18 at 12:00 pm revealed: -He was sure Staff A had completed the required 80 PCA training and competency. -The certificate should be in Staff A's personnel record. -If the certificate was not in Staff A's personnel	C937		

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C937	Continued From page 19 record, he did not know where it could be. -If Staff A needed to complete the required 80 hour PCA training and competency, he would assure that would happen. Attempted telephone interview with Staff A on 10/31/18 at 2:30 pm was unsuccessful.	C937		