STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049028	A. BUILDING: _____ B. WING _____	R 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA OF STATESVILLE	1902 ORA DRIVE STATESVILLE, NC 28625

(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 and complaint investigation on December 12 - 14, 2018. The complaint investigation was initiated by the Iredell County Department of Social Services on November 30, 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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure 4 of 7 sampled staff (Staff D, E, F, and G) were tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Staff D's personnel record revealed: -Staff D was hired on 10/11/17 as a personal care aide (PCA). -There was no documentation of a two-step TB skin test.	D 131		

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D 131	Continued From page 1 Attempted telephone interview on 12/14/18 at 10:50am with Staff D was unsuccessful. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 2:33pm with the Administrator. 2. Review of Staff E's personnel record revealed: -Staff E was hired on 08/07/18 as a personal care aide (PCA). -There was no documentation of a two-step TB skin test. Attempted telephone interview on 12/14/18 at 10:50am with Staff E was unsuccessful. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 2:33pm with the Administrator. 3. Review of Staff F's personnel record revealed: -Staff F was hired on 12/05/18 as a medication aide (MA). -There was no documentation of a TB skin test upon hire. Interview on 12/14/18 at 11:15am with Staff F revealed: -She had not had a TB skin test upon hire. -She had one TB skin test administered on	D 131		

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D 131	Continued From page 2 09/01/18 while working at another facility. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 2:33pm with the Administrator. 4. Review of Staff G's personnel record revealed: -Staff G was hired on 12/07/18 as a PCA and a MA. -There was no documentation of a TB skin test upon hire. Telephone interview on 12/14/18 at 10:00am with Staff G revealed: -She had not had a TB skin test upon hire. -She had one TB skin test administered in February 2018 while working at another facility. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 2:33pm with the Administrator. _____ Interview on 12/13/18 at 2:00pm with the BOM revealed: -She knew the TB skin tests were to be completed on all new employees. -She was not aware the TB skin tests were to be completed upon hire. -She had not had time to review all the staff	D 131		

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D 131	Continued From page 3 records. Interview on 12/14/18 at 2:00pm with the RCC revealed the BOM was responsible to schedule the TB skin tests. Interview on 12/14/18 at 2:33pm with the Administrator revealed: -She did not know the TB skin tests were not completed. -She relied on the BOM to complete new hire records. -She was not aware the BOM did not know the TB skin tests were to be completed upon hire. -She would audit personnel records on all new employees going forward. The facility failed to assure 4 of 7 sampled staff (Staff D, E, F, and G) were tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services. The facility was unaware of the status of TB testing of staff. The facility's failure to assure testing for tuberculosis was completed, was detrimental to the safety, health, 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 12/14/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 28, 2019.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137		

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D 137	Continued From page 4 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 8 sampled staff (Staff A and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G.S. 131E-256. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 03/16/18 as a personal care aide (PCA). -There was no documentation of a HCPR check prior to hire for Staff A. -Staff A's daily responsibilities included providing personal care to the residents, assisting with showers, transfers and grooming. Observations on 12/13/18 between 10:00am and 3:30pm revealed Staff A was working and providing personal care to the residents. Interview on 12/13/18 at 3:30pm with Staff A revealed: -Staff A's daily responsibilities included assisting with showers, providing personal care and transferring residents. -He did not know if a HCPR check was	D 137		

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D 137	Continued From page 5 completed prior to being hired. Interview on 12/14/18 at 2:33pm with the Administrator revealed she did not know the HCPR checks were not obtained prior to hire for Staff A. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:33pm with the Administrator. 2. Review of Staff G's personnel record revealed: -Staff G was hired on 12/07/18 as a personal care aide (PCA) and a medication aide (MA). -Staff G worked on second shift. -There was no documentation of a HCPR check prior to hire for Staff G. -Staff G's daily responsibilities included providing personal care to the residents as listed on the job description. Telephone interview on 12/14/18 at 10:00am with Staff G revealed: -Staff G's daily responsibilities included providing personal care and administering medications to the residents. -He did not know if a HCPR check was completed prior to being hired. Interview on 12/14/18 at 2:33pm with the Administrator revealed she did not know the HCPR checks were not obtained prior to hire for Staff G. Refer to interview on 12/13/18 at 2:00pm with the BOM. Refer to interview on 12/14/18 at 2:33pm with the	D 137		

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D 137	Continued From page 6 Administrator. _____ Interview on 12/13/18 at 2:00pm with the BOM revealed: -She knew the HCPR were checked on all new employees, but she did not know the HCPR checks were to be completed prior to hire. -She had not had time to review all the staff records. Interview on 12/14/18 at 2:33pm with the Administrator revealed: -She relied on the Business Office Manager (BOM) to complete new hire records. -The RCC was responsible for obtaining HCPR checks prior to employment. _____ The facility failed to ensure 2 of 8 sampled staff (Staff A and G) had no substantiated findings listed on the North Carolina HCPR prior to hire and unaware if these staff members had pending or substantiated findings. This failure was detrimental to the 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 12/14/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 28, 2019.	D 137		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel	D 161		

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D 161	Continued From page 7	D 161		

not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 6 of 7 sampled staff (Staff C, D, E, F, G, and H) were competency validated by a registered nurse with return demonstration prior to performing Licensed Health Professional Support tasks.

The findings are:

1. Review of Staff C's personnel record revealed:
-Staff C was hired on 10/02/18 as a personal care aide (PCA).
-There was no documentation of a LHPS competency validation.
-Staff C's daily responsibilities included providing personal care to the residents, assisting with showers, transfers and grooming.

Observations on 12/13/18 between 10:00am and 3:30pm revealed Staff C was working and providing personal care to the residents.

Attempted telephone interview on 12/14/18 at 11:08am with Staff C was unsuccessful.

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D 161	Continued From page 8 Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 10:35am and on 12/14/18 at 2:33pm with the Administrator. 2. Review of Staff D's personnel record revealed: -Staff D was hired on 10/11/17 as a personal care aide (PCA). -There was no documentation of a LHPS competency validation. -Staff D's daily responsibilities included providing personal care to the residents, assisting with showers, transfers and grooming. Attempted telephone interview on 12/14/18 at 11:40am with Staff D was unsuccessful. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 10:35am and on 12/14/18 at 2:33pm with the Administrator. 3. Review of Staff E's personnel record revealed: -Staff E was hired on 08/07/18 as a personal care aide (PCA). -There was no documentation of a LHPS competency validation. -Staff E's daily responsibilities included providing personal care to the residents, assisting with showers, transfers and grooming. Observations on 12/13/18 between 10:00am and	D 161		

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D 161	Continued From page 9 3:30pm revealed Staff E was working and providing personal care to the residents. Attempted telephone interview on 12/14/18 at 10:50am with Staff E was unsuccessful. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 10:35am and on 12/14/18 at 2:33pm with the Administrator. 4. Review of Staff F's personnel record revealed: -Staff F was hired on 12/05/18 as a medication aide (MA). -There was no documentation of a LHPS competency validation. -Staff F's daily responsibilities included administering medications to the residents, providing personal care, and assisting with transfers. Observation of Staff F on 12/12/18 between 11:00am and 11:15am revealed Staff F had administered medications to the residents in the facility on the front hall. Interview with Staff F on 12/12/18 at 11:15am revealed: -She had been a MA since 2000. -Third shift was responsible for obtaining Finger Sticks Blood Sugars (FSBS) but she administered the insulin if it was required. -She administered medications, inhalers, and insulin on 12/12/18 to the residents in the facility. -She had not been competency validated for LHPS.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 161	Continued From page 10 Review of the December 2018 eMAR for Resident #3 revealed Staff F administered medications which included inhalers on 12/12/18. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 10:35am and on 12/14/18 at 2:33pm with the Administrator. 5. Review of Staff G's personnel record revealed: -Staff G was hired on 12/07/18 as a personal care aide (PCA) and a medication aide (MA). -Staff G worked on second shift. -There was no documentation of a LHPS competency validation -Staff G's daily responsibilities included providing personal care to the residents as listed on the job description. Telephone interview on 12/14/18 at 10:00am with Staff G revealed: -Staff G's daily responsibilities included providing personal care and administering medications to the residents. -She had not been competency validated for LHPS. -Her responsibilities included administering oral medications, insulins and taking vital signs. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC).	D 161		

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D 161	Continued From page 11	D 161		

Refer to interview on 12/14/18 at 10:35am and on 12/14/18 at 2:33pm with the Administrator.

6. Review of Staff H's personnel record revealed:
-Staff H was hired on 11/01/18 as a medication aide (MA).
-There was no documentation of a LHPS competency validation.
-Staff H's daily responsibilities included administering medications to the residents, providing personal care, and assisting with transfers.

Observations on 12/14/18 revealed Staff H was working and administering medications to residents on the Assisted Living and SCU of the facility.

Interview on 12/14/18 at 3:30pm with Staff H revealed:
-She had not been competency validated for LHPS at this facility.
-She had completed the LHPS check-off at her previous employer.

Review of the December 2018 eMAR revelaed Staff H documented medications were administerted to the residents in the facility 9 times of 12 opportunities.

Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM).

Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC).

Refer to interview on 12/14/18 at 10:35am and on 12/14/18 at 2:33pm with the Administrator.

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D 161	Continued From page 12 Interview on 12/13/18 at 2:00pm with the BOM revealed: -She knew the LHPS check-offs were to be completed on all new employees. -She could not find the completed staff records. -She had not reviewed all the staff records because she was "only here for one month." Interview on 12/14/18 at 2:00pm with the RCC revealed: -The BOM is responsible for completing all new employees' records. -The corporate nurse was responsible for completing the LHPS check-off for clinical staff. Interview on 12/14/18 at 10:35am and on 12/14/18 at 2:33pm with the Administrator revealed: -She did not know the clinical staff LHPS check-offs were not completed. -She relied on the BOM to complete new hire records. -She relied on the RCC to schedule the MAs for all clinical training needed. -The RCC was new to the facility.	D 161		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following:	D 164		

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D 164	Continued From page 13 (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure that training on the care of residents with diabetes was provided to 3 of 3 sampled medication aides (Staff F, G, and H) prior to the administration of insulin. The findings are: 1. Review of Staff F's personnel record revealed: -Staff F was hired on 12/05/18 as a medication aide (MA). -There was no documentation of training on the care of residents with diabetes. Interview on 12/14/18 at 11:15am with Staff F revealed: -She had not completed the diabetic care training. -She worked on first shift as a MA. -Third shift was responsible for obtaining finger stick blood sugars (FSBS) but she administered insulin if it was required. -She administered medications and insulin on	D 164		

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D 164	Continued From page 14 12/12/18 to the residents in the facility. Observation of Staff F on 12/12/18 between 11:00am and 12:15pm revealed Staff F had administered medications to the residents on the Assisted Living (AL) hall. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 2:33pm with the Administrator. 2. Review of Staff G's personnel record revealed: -Staff G was hired on 12/07/18 as a personal care aide (PCA) and a MA. -There was no documentation of training on the care of residents with diabetes. Telephone interview on 12/14/18 at 10:00am with Staff G revealed: -She had not completed the diabetic care training. -Staff G's daily responsibilities included providing personal care and administering medications to the residents. -She had not been competency validated for medication clinical skills. -She had worked as a MA in another facility prior to working as a MA in this facility. -She passed the medication aide test on 09/29/16. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC).	D 164		

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D 164	Continued From page 15 Refer to interview on 12/14/18 at 2:33pm with the Administrator. 3. Review of Staff H's personnel record revealed: -Staff H was hired on 11/01/18 as a medication aide (MA). -There was no documentation of training on the care of residents with diabetes. Interview on 12/14/18 at 3:30pm with Staff H revealed: -She had not completed the diabetic care training. -She had completed the diabetic care training at her previous employer. -She performed finger stick blood sugar (FSBS) checks and gave subcutaneous insulin injections. -She administered medications on the Assisted Living (AL) side and the Special Care Unit (SCU). Observation on 12/12/18 at 11:35am revealed Staff H checked the finger stick blood sugar (FSBS) and administered Novolog insulin to a resident on the Assisted Living (AL) side. Observation on 12/12/18 at 11:46am revealed Staff H administered Novolin 70/30 insulin 15 units to a resident on the AL side. Observation on 12/12/18 at 11:59am revealed Staff H checked the FSBS and administered Humalog 50/50 insulin 4 units to a resident on the AL side. Review on 12/12/18 of the December 2018 electronic medication administration record (eMAR) revealed Staff H administered diabetic medications to residents in the facility 9 out of the past 12 days.	D 164		

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D 164	Continued From page 16 Observations on 12/14/18 at 3:00pm revealed Staff H was working and administering medications to residents on the Special Care Unit (SCU) of the facility. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 2:33pm with the Administrator. _____ Interview on 12/13/18 at 2:00pm with the BOM revealed: -She had not had time to review all the staff records. -The Administrator would oversee the completion of all staff records for compliance. Interview on 12/14/18 at 2:00pm with the RCC revealed the BOM is responsible for completing all new employees' training records. Interview on 12/14/18 at 2:33pm with the Administrator revealed: -She relied on the BOM to complete new hire records. -She would audit personnel records on all new employees going forward.	D 164		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the physician was notified of medication not in the facility for 1 of 5 sampled residents (Resident #3) related to laboratory studies not faxed to the pharmacy prior to dispensing clozapine.

The findings are:

Review of Resident #3's current FL2 dated 08/07/18 revealed:
-Diagnoses included schizophrenia.
-There was a physician order for clozapine (a medication used to treat schizophrenia) 25mg in the morning and 100 mg in the afternoon at 6:00pm.

Review of Resident #3's record revealed a signed subsequent physician order dated 10/17/18 for clozapine 100mg two times daily.

Review of Resident #3's November 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for clozapine 100mg two times daily with administration times of 9:00am and 9:00pm.
-There was documentation the clozapine 100 mg had not been administered 24 out of 60 opportunities.
-The documented reason the clozapine had not

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been administered was "medication is on reorder."

Interview on 12/12/18 at 11:50am with a medication aide (MA) revealed:
-Resident #3 had been out of his clozapine in November 2018.
-The facility had "changed pharmacy" and she thought this was the reason Resident #3 did not have the clozapine in November 2018.
-The MA had informed the Resident Care Coordinator (RCC) when Resident #3's clozapine was not available.
-The MA did not know when she had informed the RCC.
-She did not contact the physician, or know if the physician had been notified.

Interview on 12/12/18 at 3:10pm with a second MA revealed:
-The MA did not know if the Resident #3's physician had been notified due to the missed doses of clozapine.
-The lead MA or the RCC should notify the physician.
-She had not contacted Resident #3's physician in regards to the clozapine.
-She did not know why Resident #3's clozapine was not in the facility in November.

Telephone interview on 12/13/18 at 8:30am with the facility pharmacist revealed:
-Clozapine was an anti-psychotic drug used "to stabilize moods".
-The clozapine required monthly lab studies to monitor Resident #3's white blood count.
-The pharmacy had sent a request to the facility on 11/09/18 for labs studies to be faxed prior to dispensing clozapine to Resident #3.
-The pharmacy would not dispense the clozapine

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because they had not received the labs for Resident #3.
-It was the facility responsibility to fax labs and orders to the pharmacy.
The pharmacy received the labs for Resident #3 on 11/28/18.
-On 11/29/18 the pharmacy had dispensed a week supply of clozapine 100mg for Resident #3.

Interview on 12/13/18 at 10:00am with the RCC revealed:
-She was made aware the clozapine was not in the facility for administration on 11/28/18.
-She knew the pharmacy was waiting on laboratory (LAB) results for Resident #3 before they would dispense the clozapine.
-The pharmacy had requested labs for Resident #3 sometime in November (2018) after the physician had ordered them.
-Resident #3 had labs obtained 11/06/18, "I am not sure why they were not faxed to the pharmacy."
-"I guess they were overlooked."
-She never contacted the physician regarding Resident #3 not receiving clozapine from 11/17/18 through 11/28/18 because labs were not faxed to the pharmacy.
-The MAs were new and needed more education on when to call the physician.

Interview on 12/12/18 at 2:45pm with Resident #3's mental health Nurse Practitioner revealed:
-She had prescribed clozapine for Resident #3 to treat his schizophrenia.
-She did not know Resident #3 had missed taking the clozapine 11/17/18 through 11/28/18 due to labs not faxed to the pharmacy.
-She knew labs were to be obtained for the pharmacy to monitor clozapine.
-She had ordered labs 11/06/18, and they were in

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D 273	Continued From page 20 Resident #3 record. -Missing the clozapine could cause symptoms of schizophrenia to increase. -The facility staff should contact her when a medication was unavailable, "That's something I needed to know." Interview on 12/13/18 at 10:15am with the Administrator revealed: -The Administrator did not know the clozapine was not administered to Resident #3 from 11/17/18 through 11/28/18 because labs were not faxed to pharmacy. -Clozapine was used to treat Resident #3's schizophrenic. -She relied on the RCC to notify the physician when a medication was not in the facility for administration. -She relied on the RCC and the MA to fax labs and orders to the pharmacy. -The physician should be notified when a medication was not administered, "especially clozapine". -She did not know why the physician was not notified. Interview on 12/12/18 at 11:20am with Resident #3 revealed: -He knew the facility had not administered his clozapine in November 2018, but could not recall the exact days. -He relied on the facility staff to administer his medications. -He did not know if the facility staff had contacted his physician when he had not received the clozapine.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care	D 276		

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D 276	Continued From page 21 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 1 of 1 sampled residents (Resident #1) with orders for weekly weights and blood pressures. The findings are: a. Review of Resident #1's current FL2 dated 10/16/18 revealed: -Diagnoses failure to thrive and diabetes mellitus. -The blood pressure was ordered to be checked and recorded 1 time monthly and the weight was ordered to checked and recorded 1 time weekly. Review of Resident #1's October, November and December 2018 electronic Medication Administration Records (eMAR) revealed: -The October 2018 eMAR had no entry for weight documentation. -The November 2018 eMAR had no entry for weight documentation.	D 276		

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D 276	Continued From page 22 -The December 208 eMAR had no entry for weight documentation. Interview on 12/14/18 at 11:10am with a medication aide (MA) revealed: -She had never weighed Resident #1. -Since it had not been listed on the eMAR's she did not know that it needed to be done. Interview on 12/13/18 at 1:30pm with Resident #1 revealed she had not had her weight done in a long time, but could not remember when it was done last. Interview on 12/13/18 at 11:15am with the Resident Care Coordinator (RCC) revealed: -She was not aware that Resident #1 was supposed to have weekly weights. -If they were being completed they would be documented on the eMARs. Interview on 12/13/18 at 2:10pm with Resident #1's Primary Care Provider (PCP) revealed: -She did expect the staff to carry out the orders for weights. -She did not have any concerns about the weights not being done. Refer to interview on 12/13/18 at 2:10pm with Resident #1's PCP. Refer to interview on 12/14/18 at 2:50pm with the Administrator. b. Review of Resident #1's current FL2 dated 10/16/18 revealed: -Diagnoses failure to thrive and diabetes mellitus. -The blood pressure was ordered to be checked and recorded 1 time monthly.	D 276		

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D 276	Continued From page 23 Review of a subsequent physicians order dated 10/16/18 revealed "please obtain weekly BP checks and document results on MAR". Review of Resident #1's October, November and December 2018 eMAR revealed: -The October 2018 eMAR had no entry for blood pressure documentation. -The November 2018 eMAR had no entry for blood pressure documentation. -The December 208 eMAR had no entry for blood pressure documentation. Interview on 12/14/18 at 11:10am with a MA revealed: -She had never taken Resident #1's blood pressure. -Since it was not listed on the eMAR's she did not know that it needed to be done. Interview on 12/13/18 at 1:30pm with Resident #1 revealed she could not ever remember having her blood pressure done. Interview on 12/13/18 at 11:15am with the RCC revealed: -She was not aware that Resident #1 was supposed to have weekly blood pressures. -If they were being completed they would be documented on the eMARs. Interview on 12/13/18 at 2:10pm with Resident #1's PCP revealed: -She did expect the staff to carry out the orders for blood pressures. -She did not have any concerns about the blood pressures not being done. Refer to interview on 12/13/18 at 2:10pm with Resident #1's PCP.	D 276		

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D 276	Continued From page 24 Refer to interview on 12/14/18 at 2:50pm with the Administrator. Interview on 12/13/18 at 2:10pm with Resident #1's PCP revealed: -She did see Resident #1 when she was admitted to the facility. -The FL2 had been completed by the facility staff. Interview on 12/14/18 at 2:50pm with the Administrator revealed: -She expected that the physician's orders to be carried out as ordered. -The facility had not had a nurse in a while. -She did not know why the blood pressures and weights had not been done. -The previous pharmacy would not put weights or blood pressures on the eMAR.	D 276		
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.	D 358		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 3 of 5 sampled residents (#1, #3 and #4), medications used to treat psychiatric disorders, high blood pressure, hypothyroidism and anxiety for Resident #1; Medications for the treatment for psychiatric disorders and decongestant for Resident #3, and a medication used in the treatment of fluid retention for Resident #4.

The findings are:

1. Review of Resident #1's current FL2 dated 10/16/18 revealed:
-Diagnoses included bipolar disorder, GAD (generalized anxiety disorder), failure to thrive and diabetes mellitus.
-Medications ordered included perphenazine 8mg take (1) by mouth at bedtime, Prazosin 5mg take (1) capsule by mouth at bedtime, levothyroxine 112mcg take (1) by mouth 30 min before breakfast, buspirone 15mg take (1) by mouth every morning, noon and hours of sleep and lithium carbonate 300mg take (1) by mouth every morning and evening.

Review of a supplemental order sheet for Resident #1 revealed:
-"please review the orders below and verify that these are current and correct orders for the resident."
-The date on the order sheet was 10/02/18.

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-The order sheet had been completed by the facility's previous Resident Care Coordinator (RCC).
-The medications included perphenazine 8mg take (1) by mouth at bedtime, Prazosin 5mg take (1) capsule by mouth at bedtime, levothyroxine 112mcg take (1) by mouth 30 min before breakfast, buspirone 15mg take (1) by mouth every morning, noon and hours of sleep and lithium carbonate 300mg take (1) by mouth every morning and evening.
-The order sheet had been signed by Resident #1's primary provider on 10/16/18.

Review of a pharmacy medication sheet from Resident #1's previous pharmacy revealed:
-A list of medication refills from 08/01/18 to 10/04/18.
-Handwritten in the upper right hand corner were the words "New Resident List of Medications".
-The list included levothyroxine 112Mcg tablet take one tablet by mouth once daily in morning before breakfast with a dispense date of 09/12/18 of 28 tablets.
-Lithium carbonate 300mg take one capsule by mouth twice daily in the morning and in the evening with a dispense date of 09/12/18 of 28 tablets.
-Perphenazine 8mg tablet take one tablet at bedtime with a dispense date of 09/12/18 of 28 tablets.
-Buspirone Hcl 15mg tablet take one tablet three times per day morning, noon and bedtime with a dispense date of 09/12/18 of 28 tablets.
-Prazosin 5mg capsule take one tablet at bedtime with a dispense date of 08/11/18 of 28 tablets.

Review of Resident #1's October, November and December 2018 electronic Medication Administration Records (eMARs) revealed there

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was no entry for medications as ordered on 10/16/18 for:
-Perphenazine 8mg take (1) by mouth at bedtime.
-Prazosin 5mg take (1) capsule by mouth at bedtime.
-Levothyroxine 112mcg take (1) by mouth 30 min before breakfast.
-Buspirone 15mg take (1) by mouth every morning, noon and hours of sleep.
-Lithium carbonate 300mg take (1) by mouth every morning and evening.

Interview on 12/13/18 at 1:30pm with Resident #1 revealed:
-She had been on medication for her thyroid before she was admitted to the facility.
-She could not remember being on anything for blood pressures, but was on something for bladder incontinence.
-She had been on lithium prior to coming in the facility for her mood and had been on it "for a long time".
-She had noticed that she had not been getting as many medications as she was used to taking before coming to the facility, but had not said anything to anyone.
-She thought she was still getting her medications for her thyroid.
-She had told the doctor when she was admitted that she was on thyroid medication.
-She had brought in all her medications when she was admitted, but did not know what had happened to them.

Interview on 12/13/18 at 11:15am with the RCC revealed:
-She was not aware that Resident #1 had any medications missing from her eMAR.
-The FL2 on Resident #1 was completed by the previous RCC.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-The previous pharmacy would not use the FL2 as an order.
-She was not working at the facility when Resident #1 was admitted.
-The facility was using a new pharmacy now because of "problems with the last pharmacy".

Interview on 12/13/18 at 2:10pm with Resident #1's Primary Care Provider revealed:
-She did see Resident #1 when she was admitted to the facility.
-She had been handed an eMAR for Resident #1 with her current medications.
-She considered the medications on the eMAR as the current medications for the resident.
-The resident should have come in with an FL2 which listed her medications that she had been on.
-She did not recall seeing any additional medication lists for Resident #1.
-She did not "fill in" the FL2 for the residents; she just signed what was put in front of her and assumed it is right.
-The FL2 had been completed by the facility staff.
-"I don't think she should be on the blood pressure or thyroid medications."
-She was not responsible for the mental health medications.

Interview on 12/14/18 at 11:10am with a, medication aide (MA) revealed she did not recall ever administering perphenazine, prazosin, levothyroxine, buspirone or lithium carbonate to Resident #1.

Attempted telephone interview on 12/14/18 at 12:20pm with Resident #1's mental health provider was unsuccessful.

Attempted telephone interview on 12/14/18 at

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D 358	Continued From page 29 11:45am with the facility's previous pharmacy was unsuccessful. Interview on 12/14/18 at 2:45pm with a representative from the current facility pharmacy provider revealed: -They had been providing services to the facility since 11/01/18. -The previous pharmacy would not accept the FL2 as a valid order for the residents. -The Provider had to write "hard scripts" for all medications the residents were on. Interview on 12/14/18 at 2:50pm with the Administrator revealed: -She expected that the physician's orders to be carried out as ordered. -The facility had not had a nurse in a while. -She did not know why the provider signed the FL2 if she did not want the medications on the eMAR. 2. Review of Resident #4's current FL2 dated 06/21/18 revealed diagnoses included dementia, gastroesophageal reflux disease, diabetes, hyperlipidemia, systolic heart failure, anemia, coronary artery disease, glaucoma, hyperkalemia, osteoarthritis. Review of Resident #4's physician's orders revealed: -There was a physician's order dated 10/22/18 to give 1 tablet furosemide (a medication used to treat fluid retention) 20mg daily as needed if resident gains 2 to 3 pounds in 24 hours or 3 pounds in 3 days. -There was a physician's order dated 10/22/18 to check Resident #4's weight daily if resident gains 2 to 3 pounds in 24 hours or 3 pounds in 3 days give the as needed furosemide.	D 358		

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D 358	Continued From page 30 Review of Resident #4's electronic Medication Administration Record (eMAR) for November 2018 revealed: -There was an entry for furosemide 20mg daily as needed if resident gains 2 to 3 pounds in 24 hours or 3 pounds in 3 days. -On 11/01/18, Resident #4's weight was documented as 156 pounds and on 11/02/18, Resident #4's weight was documented as 163 pounds. -On 11/04/18, Resident #4's weight was documented as 156 pounds and on 11/05/18, Resident #4's weight was documented as 159 pounds. -On 11/05/18, Resident #4's weight was documented as 156 pounds and on 11/06/18, Resident #4's weight was documented as 165 pounds. -On 11/21/18, Resident #4's weight was documented as 156 pounds and on 11/22/18, Resident #4's weight was documented as 165 pounds. -On 11/24/18, Resident #4's weight was documented as 156 pounds and on 11/25/18, Resident #4's weight was documented as 165 pounds. -On 11/29/18, Resident #4's weight was documented as 155 pounds and on 11/30/18, Resident #4's weight was documented as 160 pounds. -There was no documentation that furosemide was given based on the documented weights 6 times the as needed furosemide should haven been given. Review of Resident #4's eMAR for December 2018 revealed: . -There was an entry for furosemide 20mg daily as needed if resident gains 2 to 3 pounds in 24	D 358		

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hours or 3 pounds in 3 days.
-On 12/01/18, Resident #4's weight was documented as 156 pounds and on 12/02/18, Resident #4's weight was documented as 165 pounds.
-There was no documentation that furosemide was given at any time throughout the month of December.

Observation of Resident #4's medications on hand on 11/08/18 at 12:30pm revealed there were 16 tablets of 30 tablets of furosemide 20mg tablets dispensed on 08/03/18 available.

Interview with the medication aide (MA) on 11/12/18 at 2:57pm revealed:
-She knew Resident #4 had daily weights and furosemide ordered as needed for weight gain.
-She did not know how to review Resident #4's weight history to know her weight in the eMAR.
-She knew how to document Resident #4's daily weight.
-She had not administered Resident #4's furosemide for increase weight gain.

Interview with the Resident Care Coordinator (RCC) on 12/13/18 at 10:20am revealed:
-She knew Resident #4 had daily weight and furosemide ordered as need for weight gain.
-She knew how to review Resident #4's daily weights, but she had not needed to administer furosemide.
-She did not know the MAs did not know how review Resident #4's weight history on the eMAR.
-She had not been asked by the MAs to show them how to review Resident #4's daily weights.
-She did not know Resident #4 had not received furosemide as needed for weight gain.

Attempted telephone interview with Resident #4's

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Nurse Practitioner on 12/13/18 at 11:29am was unsuccessful.

Interview with the Administrator on 12/13/18 at 10:30am revealed:
-She did not know Resident #4 had not received furosemide as needed for weight gain.
-The facility had changed to a new pharmacy and they were currently completing a medication review of the resident records.
-She did not know the MAs did not know how to review Resident #4's weight history.

3. a. Review of Resident #3's current FL2 dated 08/07/18 revealed:
-Diagnoses included schizophrenia.
-There was a physician order for clozapine (medication used to treat schizophrenia) 25mg in the morning and 100 mg in the afternoon at 6:00pm.

Review of Resident #3's record revealed a signed physician order dated 10/17/18 for clozapine100mg two times daily.

Review of Resident #3's November 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for clozapine 100mg two times daily with administration time of 9:00am and 9:00pm.
-There was documentation the clozapine 100 mg had not been administered 36 out of 60 opportunities.
-The documented reason the clozapine had not been administered was "medication is on reorder".

Observation on 12/12/18 at 3:45pm of medication on hand for Resident #3 revealed there were 5

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D 358	Continued From page 33 clozapine 100 mg tablets for administration. Interview on 12/12/18 at 11:50am with a medication aide (MA) revealed: -Resident #3 had been out of his clozapine in November 2018. -The pharmacy had not sent the clozapine. -The clozapine was used for Resident #3's "mental health." -She was not sure why the pharmacy had not sent Resident #3's clozapine 100mg to the facility. Interview on 12/12/18 at 3:10pm with a second MA revealed: -The facility had a new pharmacy that started 11/01/18. -The MAs faxed orders to pharmacy and the Resident Care Coordinator (RCC) verified the order in the eMAR system. -She thought Resident #3 did not receive the clozapine because "it was on back order." -She never contacted the pharmacy about the clozapine. Interview on 12/13/18 at 10:00am with the RCC revealed: -The MAs had not informed her Resident #3's clozapine was not available for administration in November 2018. -She was aware Resident #3's clozapine was not in the facility for administration on 11/28/18. -The pharmacy had sent the facility a request for laboratory (LAB) results for Resident #3 before they could dispense the clozapine. -She had faxed Resident #3's labs to pharmacy on 11/28/18. -Resident #3 labs were obtained 11/06/18, "I am not sure why they were not faxed to the pharmacy."	D 358		

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D 358	Continued From page 34 "I guess they were overlooked." Telephone interview on 12/13/18 at 8:30am with the facility pharmacist revealed: -Clozapine was an anti-psychotic drug used "to stabilize moods". -The clozapine required monthly lab studies to monitor Resident #3's white blood count. -The pharmacy would not dispense the clozapine because they had not received the labs for Resident #3. -It was the facility responsibility to fax labs and orders to the pharmacy. The pharmacy received the labs for Resident #3 on 11/28/18. -On 11/29/18 the pharmacy had dispensed a week supply of clozapine 100mg for Resident #3. Interview on 12/12/18 at 2:45pm with Resident #3's mental health Nurse Practitioner revealed: -She had prescribed clozapine for Resident #3 for his schizophrenia. -She did not know the facility had not administered Resident #3 clozapine 11/17/18 through 11/28/18. -She ordered labs on 11/06/18 and they were in Resident #3 record. -Not administering the clozapine could cause "symptoms of schizophrenia to increase." -The facility is responsible for administering medications as they are prescribed. Interview on 12/13/18 at 10:15am with the Administrator revealed: -The Administrator did not know the clozapine was not administered to Resident #3 from 11/17/18 through 11/28/18. -The facility changed pharmacies 11/01/18 "Maybe that is why the mix-up on the clozapine." -The MAs and the RCC was responsible for	D 358		

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faxing orders and labs to the pharmacy.

Interview on 12/12/18 at 11:20am with Resident #3 reveled:
-He knew the facility had not administered his clozapine in November 2018, but could not recall the exact days.
-He relied on the facility staff to administer his medications.

b. Review of Resident #3's current FL2 dated 08/07/18 revealed there was a physician order for Mucinex 600-30mg two times daily.

Review of Resident #3's record revealed a signed physician order dated 12/04/18 "please D/C Mucinex off MAR, this was written on 9/11/18 and was only for 30 day supply."

Review of Resident #3's November 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Mucinex DM ER 600-30mg 1 tablet twice daily at 9:00am and 9:00pm.
-There was documentation the Mucinex had been administered 57 out of 60 opportunities.

Review of Resident #3's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Mucinex DM ER 600-30mg 1 tablet twice daily at 9:00am and 9:00pm.
-There was documentation the Mucinex had been administered from 12/01/18 through 12/12/18.
-There was documentation Mucinex 600-30mg was discontinued (D/C'd) on 12/13/18.

Observation on 12/12/18 at 3:45pm of medication

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on hand for Resident #3 revealed there were 26 Mucinex 600-30mg tablets for administration.

Interview on 12/12/18 at 3:10pm with a MA revealed:
-The Mucinex was an active order on the eMAR for Resident #3.
-The MAs faxed orders to pharmacy but cannot verify the new orders on the eMAR system.
-The RCC or the Administrator were the only two who could verify or discontinue orders.

Telephone interview on 12/13/18 at 8:30am with the facility pharmacist revealed Resident #3' had an active order for Mucinex 600-30mg two times daily.

Interview on 12/13/18 at 10:00am with the RCC revealed:
-She knew the NP had written an order to D/C the Mucinex on 12/04/18.
-She had faxed the order to pharmacy on 12/04/18.
-She was unsure why the Mucinex was still on Resident #3's profile on the eMAR for administration.
-"The facility had trouble with the fax machine so maybe the pharmacy did not receive the fax."

Telephone interview on 12/13/18 at 2:10pm with the Nurse Practitioner revealed:
-She had written an order on 09/11/18 for a 30 day supply of Mucinex for Resident #3.
-She had reviewed Resident #3's eMAR in December 2018 and found an entry for Mucinex.
-She had written another order to discontinue the Mucinex on 12/04/18.
-She was not aware the Mucinex was still being administered to Resident #3 as of 12/12/18.
-It was the staffs responsibility to discontinue

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D 358	Continued From page 37 medications as ordered. ___ The facility failed to assure medications were administered as ordered by a licensed prescribing practitioner resulting in Resident #1 not receiving medications for 2 months from 10/16/18 to 12/04/18, Resident #2 not receiving clozapine from 11/17/18 to 11/28/18 and Mucinex administered without an order for 2 months, Resident #4 diagnosis with congestive heart failure gained weight on 5 occasions without staff administering the furosemide as ordered. This failure of not receiving medications as ordered can result in failure to treat diseases properly or exacerbations of clinical symptoms which was detrimental to the health and safety of the residents and constitutes a Type B Violation. ___ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/13/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 28, 2019.	D 358		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the	D 468		

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administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement.
(2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents.
(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff assigned to perform duties in a Special Care Unit, received 6 hours of orientation training within the first week of employment (Staff H)

The findings are:

Review of Staff H's personnel record revealed:
-Staff H was hired on 11/01/18 as a medication aide (MA).
-There was no documentation of 6 hours of Special Care Unit (SCU) training within the first

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week of employment.
-Staff H's daily responsibilities included administering medications to the residents, providing personal care, and assisting with transfers.

Observations on 12/14/18 at 3:00pm revealed Staff H was working and administering medications to residents in the SCU.

Interview on 12/14/18 at 3:30pm with Staff H revealed:
-She had not completed the 6 hours of SCU training within the first week of employment.
-She worked as a MA on the SCU and the Assisted Living (AL) side.

Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM).

Refer to interview on 12/14/18 at 2:33pm with the Administrator.

Interview with the BOM on 12/13/18 at 2:00pm revealed:
-All staff worked in the SCU and were crossed trained.
-"We try to keep the same staff in the SCU but sometimes we need to pull staff over."
-The SCU training had not been completed for the new employees.
-She could not find the completed staff records.
-She had not reviewed the staff records because "I've only been here one month."

Interview on 12/14/18 at 2:33pm with the Administrator revealed:
-She did not know the 6 hours SCU training had not been completed for Staff H.
-She relied on the BOM to complete new hire

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D 468	Continued From page 40 records.	D 468		
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 ensure resident received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration, test for tuberculosis, adult care home medication aides training and competency evaluation requirements, and other staff qualifications. The findings are: 1. Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 3 of 5 sampled residents (#1, #3 and #4), medications used to treat psychiatric disorders, high blood pressure, hypothyroidism and anxiety for Resident #1; medications for the treatment for psychiatric disorders and decongestant for Resident #3, and a medication used in the treatment of fluid retention for Resident #4. [Refer to Tag 0358, 10A	D912		

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D912	Continued From page 41 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to assure 4 of 7 sampled staff (Staff D, E, F, and G) were tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 0131, 10A 13F .0406(a) Test For Tuberculosis (Type B Violation)]. 3. Based on interviews and record reviews, the facility failed to assure 3 of 3 sampled medication aides (Staff F, G, and H) completed the medication clinical skills validation prior to the administration of medications in the facility. [Refer to Tag 0935, G.S. 131D-4.5B(b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)]. 4. Based on interviews and record reviews, the facility failed to ensure 2 of 8 sampled staff (Staff A and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G.S. 131E-256. [Refer to Tag 0137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (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	D935		

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	HAL049028	A. BUILDING: _____ B. WING _____	R 12/14/2018

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D935	Continued From page 42 that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and 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:	D935		

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D935	Continued From page 43 TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure 3 of 3 sampled medication aides (Staff F, G, and H) completed the medication clinical skills validation prior to the administration of medications in the facility. The findings are: 1. Review of Staff F's personnel record revealed: -Staff F was hired on 12/05/18 as a medication aide (MA). -There was no documentation of a medication clinical skills competency validation. -Staff F's daily responsibilities included administering medications to the residents, providing personal care, and assisting with transfers. -She had passed the MA exam on 10/10/01. -She had worked as a MA in another facility for 24 months prior to working as a MA in this facility. -There was documentation of MA employment verification dated 12/04/18. Interview with the Resident Care Coordinator (RCC) on 12/12/18 at 11:23am revealed: -Staff F was a new MA. -Staff F would be trained 2 or 3 days on the medication cart. -Staff F was on the medication cart on 12/12/18 and administered medications to the residents. -The RCC was available if she had any questions with the electronic medication record (eMAR) system or the resident's medications. Interview on 12/14/18 at 11:15am with Staff F revealed: -She had not been competency validated for medication clinical skills.	D935		

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D935	Continued From page 44 -She worked on first shift as a MA. -The RCC was training her on the medication cart. -Third shift was responsible for obtaining finger stick blood sugars (FSBS) but she administered the insulin if it was required. -She administered medications and insulin on 12/12/18 to the residents in the facility. Interview on 12/14/18 at 3:30pm with Staff F revealed: -Her duties included administering medications and administering insulin to residents. -She had passed the MA exam on 10/10/01. -She was hired about 5 days ago as a MA and she was currently in training. Observation of Staff F on 12/12/18 between 11:00am and 12:15pm revealed Staff F had administered medications to the residents on the Assisted Living (AL) hall. Review of the December 2018 eMAR for Resident #3 revealed Staff F administered medications which included narcotics and inhalers on 12/12/18. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 2:30pm with the facility's contracted pharmacist. Refer to interview on 12/14/18 at 10:35am and 2:33pm with the Administrator. 2. Review of Staff G's personnel record revealed:	D935		

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D935	Continued From page 45 -Staff G was hired on 12/07/18 as a personal care aide (PCA) and a medication aide (MA). -There was no documentation of a medication clinical skills competency validation. -Staff G's daily responsibilities included administering medications to the residents and providing personal care. -She had passed the MA exam on 09/29/16 -She had taken the 15 hour medication training class on 09/30/16. Telephone interview on 12/14/18 at 10:00am with Staff G revealed: -Staff G's daily responsibilities included providing personal care and administering medications to the residents. -She had not been competency validated for medication clinical skills. -She was training on first shift as a MA. -She was hired as a MA but was in training on the cart. -She had worked as a MA in another facility prior to working as a MA in this facility. -She passed the medication aide test on 09/29/16. -She had not completed a medication skills validation because she was told by the RCC she would complete the skill validation after she finished the training on the medication cart. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 2:30pm with the facility's contracted pharmacist. Refer to interview on 12/14/18 at 10:35am and	D935		

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D935	Continued From page 46 2:33pm with the Administrator. 3. Review of Staff H's personnel record revealed: -Staff H was hired on 11/01/18 as a medication aide (MA). -There was no documentation of a medication clinical skills competency validation. -Staff H's daily responsibilities included administering medications to the residents, providing personal care, and assisting with transfers. -She had passed the MA exam on 02/20/18. Observation on 12/12/18 at 11:35am revealed Staff H checked the finger stick blood sugar (FSBS) and administered Novolog insulin to a resident on the Assisted Living (AL) side. Observation on 12/12/18 at 11:46am revealed Staff H administered Novolin 70/30 insulin 15 units to a resident on the AL side. Observation on 12/12/18 at 11:59am revealed Staff H checked the FSBS and administered Humalog 50/50 insulin 4 units to a resident on the AL side. Review on 12/12/18 of the December 2018 electronic medication administration record (eMAR) revealed Staff H administered medications to residents in the facility 9 out of the past 12 days. Observations on 12/14/18 at 3:00pm revealed Staff H was working and administering medications to residents on the Special Care Unit (SCU) of the facility. Interview on 12/14/18 at 3:30pm with Staff H revealed:	D935		

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D935	Continued From page 47 -She had not been competency validated for medication clinical skills at this facility. -She had taken the 15 hour medication training class prior to working at this facility. -She performed FSBS checks and gave subcutaneous insulin injections. -She administered medications on the AL side and the SCU. Refer to interview on 12/13/18 at 2:00pm with the Business Office Manager (BOM). Refer to interview on 12/14/18 at 2:00pm with the Resident Care Coordinator (RCC). Refer to interview on 12/14/18 at 2:30pm with the facility's contracted pharmacist. Refer to interview on 12/14/18 at 10:35am and 2:33pm with the Administrator. _____ Interview on 12/13/18 at 2:00pm with the BOM revealed: -She knew the medication clinical skills checklist was to be completed on all new MAs. -She had not had time to review all the staff records. Interview on 12/14/18 at 2:00pm with the RCC revealed: -She did not know the MAs needed the medication clinical skills checklist prior to working on the medication carts. -The MAs in training did not have the medication clinical skills checklist. Interview on 12/14/18 at 2:30pm with the facility's contracted pharmacist revealed: -The RCC was not aware the MAs needed the	D935		

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D935	Continued From page 48 skills validation prior to working the cart and administering medications. -She had taken over pharmacy services about a month ago. -One of her responsibilities included the 5/10/15 hour MA training and completing the skills validation checklist for all MAs prior to administering medications to residents. -She had not validated these MAs for medication clinical skills prior to 12/14/18. -Interview on 12/14/18 at 10:35am and 2:33pm with the Administrator revealed: -She relied on the RCC to schedule the MAs for all clinical training needed. -The RCC was new to the facility. -She did not know the medication clinical skills checklists were not completed prior to administering medications to the residents. -She relied on the BOM to complete new hire records. _____ The facility failed to assure 3 of 3 sampled medication aides (Staff F, G, and H) completed the medication clinical skills validation prior to the administration of medications. The facility's failure to assure training was completed by the MAs was detrimental to the safety, health, 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 12/14/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 28, 2019.	D935		