STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034019	A. BUILDING: _____ B. WING _____	R 01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R T - GOLDEN LAMB REST HOME	1515 GOLDEN LAMB COURT WINSTON SALEM, NC 27105

(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 a follow-up survey and complaint investigation on January 15 - 16, 2019.	{D 000}		
{D 139}	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to assure 1 of 4 sampled staff (Staff A) had a criminal background check completed upon hire. The findings are: Review of Staff A, transportation aide/housekeeper's personnel record revealed: -She was hired on 01/07/19. -There was no documentation that a criminal background check had been completed. Observation of Staff A on 01/15/19 at 8:38 am revealed that she carried towels and washcloths to the women's shower room. Interview with Staff A on 01/16/19 at 11:50 am revealed: -She was hired a week ago as a transportation and laundry aide.	{D 139}		

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{D 139}	Continued From page 1 -She did not recall signing a consent for a criminal background check. -She did not know if a criminal background check had been completed. -She had previously worked at the facility. Interview with the Administrator on 01/16/19 at 3:23 pm revealed: -Staff A was hired on 01/07/19 as a transportation and laundry aide. -She knew the employee needed to have a criminal background check before hire. -The Administrative Assistant was responsible for completing personnel records. -"No one had been put in place to oversee what he was doing." Interview with the Administrative Assistant on 01/16/19 at 3:30 pm revealed: -He did not know Staff A did not have a criminal background check in her employee record. -He did not know why there was not a criminal background check completed. -The criminal background check process would be started immediately. _____ The facility failed to ensure Staff A had a criminal background check completed prior to hire. The facility's failure resulted in the facility being unaware of any criminal background history, which was detrimental to the safety and welfare of the residents and constitutes an unabated Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/16/19 for this violation.	{D 139}		

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D 344	Continued From page 2	D 344		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 1 of 3 sampled residents (Resident #1) regarding an order for Novolin insulin and Levemir insulin. The findings are: Review of Resident #1's current FL2 dated 10/29/18 revealed: - Diagnoses included diabetes, hypothyroidism, dementia, altered mental status, acute renal failure, and thyroid cancer. -There was an order for Novolin Insulin (a short acting insulin used to treat high blood sugar) per	D 344		

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sliding scale (SS). (The sliding scale parameters were not listed on the FL2.)
-There was an order for Levemir Insulin (a long acting insulin used to treat high blood sugar). "Inject 8 units into the skin "PO" (by mouth).
-There was an order for finger stick blood sugar (FSBS) checks before breakfast on Tuesdays, Thursdays, Saturdays, and Sundays.
-There was an order for FSBS checks before supper on Mondays, Wednesdays, and Fridays.

Review of Resident #1's previous FL2 dated 06/29/18 revealed:
- Diagnoses included diabetes, hypothyroidism, dementia, altered mental status, acute renal failure, and thyroid cancer.
-There was an order for Novolin SSI inject SQ (subcutaneous) per sliding scale: >150=2 units; >200=4 units; >250=6 units; >300= 8units; >350=10 units.
-There was no order for Levemir insulin.
-There was an order for finger stick blood sugar (FSBS) checks before breakfast on Tuesdays, Thursdays, Saturdays, and Sundays.
-There was an order for FSBS checks before supper on Mondays, Wednesdays, and Fridays.

Review of Resident #1's physician's orders revealed:
-There was no clarification of Resident #1's Novolin sliding scale insulin (SSI) parameters.
-There was no clarification of Resident #1's Levemir for the appropriate route of administration or when to administer the insulin.

Review of Resident #4's October 2018 medication administration record (MAR) revealed:
-There was a pre-printed entry for FSBS checks before breakfast on Tuesdays, Thursdays, Saturdays, and Sundays.

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-There was a pre-printed entry for FSBS checks before supper on Mondays, Wednesdays, and Fridays.
-There was a pre-printed entry for Novolin Insulin per sliding scale.
-There were handwritten instructions below the Novolin as follows: 150=2 units, 200=4 units, 250=6 units, 300=8 units, 350=10 units.
-There was documentation Resident #1 was administered Novolin Insulin six times from 10/01/18 to 10/10/18.
-There was a pre-printed entry for Levemir. Inject 8 units into the skin once daily at 8:00 pm.
-There was documentation Resident #1 was administered Levemir Insulin six times from 10/01/18 to 10/10/18 at 8:00 pm.

Review of Resident #1's November 2018 MAR revealed:
-There was a pre-printed entry for glucometers before breakfast on Tuesdays, Thursdays, Saturdays, and Sundays.
-There was a pre-printed entry for glucometers before supper on Mondays, Wednesdays, and Fridays.
-There was a pre-printed entry for Novolin Insulin per sliding scale.
-There was handwritten instruction below the Novolin as follows: 150=2 units, 200=4 units, 250=6 units, 300=8 units, 350=10 units.
-The equal to sign was marked over by a greater than sign (>).
-There was documentation Resident #1 was administered Novolin Insulin 19 times from 11/01/18 to 11/30/18.
-There was a pre-printed entry for Levemir. Inject 8 units into the skin once daily at 8:00 pm.
-There was documentation Resident #1 was administered Levemir Insulin 28 times from 11/01/18 to 11/30/18 at 8:00 pm.

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D 344	Continued From page 5 Review of Resident #1's December 2018 MAR revealed: -There was a pre-printed entry for glucometers before breakfast on Tuesdays, Thursdays, Saturdays, and Sundays. -There was a pre-printed entry for glucometers before supper on Mondays, Wednesdays, and Fridays. -There was a pre-printed entry for Novolin Insulin per sliding scale. Inject 2-10 units S.Q. per SS. -There was a handwritten entry for the Novolin as follows: 150>2 units, 200>4 units, 250>6 units, 300>8 units, 350>10 units. -There was documentation Resident #1 was administered Novolin Insulin 9 times from 12/01/18 to 12/22/18. -There was a pre-printed entry for Levemir. Inject 8 units into the skin once daily at 8:00 pm. -There was documentation Resident #1 was administered Levemir Insulin 15 times from 12/01/18 to 12/22/18 at 8:00 pm. Review of Resident #1's record revealed: -There was no documentation Resident #1's provider had been contacted to clarify the parameters for the SSI. -There was no documentation Resident #1's provider had been contacted to clarify the route and frequency of the Levemir injection. Observation of insulin supplies on 01/16/19 at 3:00 pm revealed there were only insulin syringes available on the medication cart. Based on interviews, and record reviews it was determined Resident #1 was not available for interview on 01/16/19. Telephone interview with the Pharmacist at the	D 344		

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contracted pharmacy on 01/15/19 at 3:05 pm revealed:
-The pharmacy did not use FL2 to fill medications.
-The pharmacy received all orders directly from the physician.
-The Novolin order was entered into the system "verbatim".
-The pharmacy did not clarify orders from the physician.
-"All injections go into the skin including intramuscular injections".
-He did not know if there would be any negative effects of the insulin being given in the skin instead of subcutaneously.

Interview with the facility Nurse on 01/16/19 at revealed:
-She was recently hired and was not there when while Resident #1 was there.
-Any orders that were not clear should be clarified by the MA's with the prescribing physician.

Telephone interview with the Nurse Practitioner from Resident #1's primary care providers (PCP) office on 01/16/19 at 9:50 am revealed:
-The facility had not contacted the PCP for clarification of either insulin order.
-The facility had the parameters for the SSI.
-The Levemir injection was administered daily subcutaneously (SQ).
-It was not the physician's responsibility to learn how the facility wanted the SSI orders written.
-It was the facility's responsibility to let the physician know if she needed to write orders differently.
-She did not answer if there would be any negative effects of the SSI being administered into the skin versus SQ.

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D 344	Continued From page 7 Interview with a medication aide on 01/15/19 at 2:30 pm revealed: -Orders are entered into the computer by the pharmacy. -MA's clarified orders when they were missing information or were not clear. -She "knew" insulin was given SQ and not in the skin. Interview with the Administrative Assistant on 01/5/19 at 2:45 pm revealed: -The FL2 was just "misdone" and the physician signed it. -"I really don't know what happened". -The Nurse was now responsible for completing the FL2's. Interview with the Administrator on 01/15/19 at 3:45 pm revealed: -There probably was not a clarification order for either insulin. -The medication aides were responsible for obtaining clarifications of orders when needed. -She was responsible for ensuring all orders were understood. -No additional information was provided.	D 344		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	{D 358}		

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{D 358}	Continued From page 8	{D 358}		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents sampled (Resident #2) with an order for Vitamin B12 (Resident #2).

The findings are:

Review of Resident #2's current FL2 dated 07/18/18 revealed:
-Diagnoses included Alzheimer's dementia, congestive heart failure, vitamin S deficiency, and urinary incontinence.
-A physician's order for Vitamin B12 100 mcg every day.

Review of Resident #2's November 2018 Medication Administration Record (MAR) revealed:
-There was an entry for Vitamin B12 100 mcg every day at 8:00 am.
-Staff documented Vitamin B12 was administered daily from 11/01/18 to 11/30/18 at 8:00 am.

Review of Resident #2's December 2018 MAR revealed:
-There was an entry for Vitamin B12 100 mcg every day at 8:00 am
-Staff documented Vitamin B12 was administered

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{D 358}	Continued From page 9 daily from 12/01/18 to 12/31/18 at 8:00 am. Review of Resident #2's January 2019 MAR revealed: -There was an entry for Vitamin B12 100 mcg every day at 8:00 am. -Staff documented Vitamin B12 was administered daily from 01/01/19 to 01/16/19 at 8:00 am. Observation of medication on hand for Resident #2 revealed there was no Vitamin B12 available for administration. Interview with a MA on 01/16/18 at 10:30 pm revealed: -She had administered the Vitamin B12 to Resident #2 this morning, "that must have been the last dose". -She was unable to locate the empty container of B12. -She was unable to locate an unopened container or bubble card of Vitamin B12. -"The resident's family supplied us with the Vitamin B12. It did not come from the contracted pharmacy" Telephone interview with the contracted pharmacy representative on 01/16/18 at 10:50 am revealed: -The pharmacy filled the prescription of Vitamin B12 on 09/18/18 with 30 tablets. -The facility would have run out of Vitamin B12 on 10/18/18. -The pharmacy had not filled the prescription since 09/18/18. -The facility had to request medication refills when needed. -The facility had not requested a refill of the Vitamin B12.	{D 358}		

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{D 358}	Continued From page 10 Interview with Resident #2's family member on 01/16/18 at 1:10 pm revealed: -She did not know what medications were administered to Resident #2. -The facility staff provided all of Resident #2's medication. Attempted interview on 01/16/18 at 11:00 am with Resident #2's physician was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to other staff qualifications and medication aides training and competency. The findings are: 1. Based on record reviews and interviews, the	{D912}		

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{D912}	Continued From page 11 facility failed to assure 1 of 4 sampled staff (Staff A) had a criminal background check completed in accordance with G.S. 114-19. 10 and 131D-40. [Refer to Tag D 0139, 10A NCAC 13F .0407 (a) (7) Other Staff Qualifications (Unabated Type B Violation).] 2. Based on observations, interview and record reviews the facility failed to assure 2 of 4 sampled staff (Staff C and Staff D) who administered medications, had employment verification or completed the 5, 10, or 15 hour medication administration training courses and completed an Medication Clinical Skills Competency validation prior to administering medications. [Refer to Tag D 935, G.S. 131D 4.5 B(b) ACH Medication Aides; Training and Competency (Type B Violation).]	{D912}		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and	D935		

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D935	Continued From page 12 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: TYPE B VIOLATION Based on interviews and record reviews the facility failed to assure 2 of 4 sampled staff (Staff C and Staff D) who administered medications, had employment verification or completed the 10 hour medication administration training courses and had a medication clinical skills competency validation prior to administering medications.	D935		

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D935	Continued From page 13 The findings are: 1. Review of Staff C, medication aide's (MA) personnel record revealed: -Staff C was hired on 01/02/17. -There was documentation Staff C passed the written medication administration examination on 05/16/02. -There was documentation Staff C completed the 5 hour MA training on 02/16/17 and 04/06/17 . -There was no documentation Staff C completed the 10 hour MA training. -There was no documentation of employment verification showing Staff C worked as a medication aide within the last 24 months. -There was no documentation of a medication clinical skills competency validation. Review of a resident's November 2018 Medication Administration Record (MAR) revealed: -Staff C documented administration of medications from 11/02/18 through 11/04/18, from 11/07/18 through 11/09/18, from 11/13/18 through 11/15/18, 11/22/18, 11/23/18, 11/25/18, 11/26/18 and 11/30/18. Review of a resident's December 2018 MAR revealed: -Staff C documented administration of medications on 12/01/18, 12/02/18, from 12/05/18 through 12/07/18, from 12/11/18 through 12/13/18, 12/17/18, 12/18/18, from 12/22/18 through 12/24/18 and from 12/28/18 through 12/30/18. Review of a resident's January 2019 MAR revealed: -Staff C documented administration of medications from 01/02/19 through 01/03/19,	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034019	A. BUILDING: _____ B. WING _____	R 01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R T - GOLDEN LAMB REST HOME	1515 GOLDEN LAMB COURT WINSTON SALEM, NC 27105

(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
D935	Continued From page 14 from 01/08/19 through 01/10/19, 01/14/19 and 01/15/19. Interview with Staff C on 01/15/19 at 11:45 am revealed: -She had worked at the facility "for about a year". -Her duties included "passing out all medications", performing fingerstick blood sugars and administering insulin. -She did not know if she had completed the 10 hour MA training. Refer to interview on 01/16/19 at 11:00 am with the facility Nurse. 2. Review of Staff D, medication aide's (MA) personnel record revealed: -Staff D was hired on 01/04/10. -There was documentation Staff D passed the written medication administration examination on 08/18/16. -There was documentation Staff D completed the 5 hour MA training on 02/16/17. -There was no documentation Staff D completed the 10 hour MA training. -There was no documentation of employment verification showing Staff D worked as a medication aide within the last 24 months. -There was no documentation of a medication clinical skills competency validation. Review of a resident's November 2018 Medication Administration Record (MAR) revealed: -Staff D documented administration of medications on 11/05/18 and 11/24/18. Review of a resident's December 2018 MAR revealed: -Staff D documented administration of	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034019	A. BUILDING: _____ B. WING _____	R 01/16/2019

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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
D935	Continued From page 15 medications on 12/04/18. Review of a resident's January 2019 MAR revealed: -Staff D documented administration of medications on 01/02/19, 01/04/19 and 01/10/19. Interview with Staff D on 01/15/19 at 2:45 pm revealed: -He worked at the facility "since 2010". -He worked in the business office, but he also worked on the floor as a MA when needed. -His duties included "passing out all medications as ordered", performing fingerstick blood sugars and administering insulin. -He did not know if he had completed the 10 hour MA training. Interview with the facility Nurse on 01/16/19 at 11:00 am revealed: -She did not know the medication clinical skills competency validation was required for any facility staff. -She did not complete the medication clinical skills competency validation for any facility staff. -"I didn't know I needed to complete that form". -She did not know the 10 hour MA training was required in addition to the 5 hour MA training for any MA for whom employment verification was not completed up on hire. -"I thought the 5 hour training was all that was needed". The facility failed to assure medication aides had completed the 15 hour state approved medication aide training and completed a medication aide clinical skill competency evaluation prior to performing unsupervised medication aide duties, which placed all residents at risk for medication errors. The facility's failure was detrimental to the	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D935	Continued From page 16 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 01/16/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 02, 2019.	D935		