STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018024	A. BUILDING: _____ B. WING _____	07/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATAWBA VALLEY LIVING AT ROCK BARN	4174 SHOOK ROAD CONOVER, NC 28613

(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 July 2-3, 2019.	D 000		
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: (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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 4 of 4 sampled Medication Aides (Staff A, B, D, and E)	D 164		

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D 164	Continued From page 1	D 164		

who administered insulin and performed finger stick blood sugar checks for residents completed training on the care of diabetic residents prior to the administration of insulin.

The findings are:

1. Review of Staff A's personnel record revealed:
-Staff A was hired in March 2016 as a Medication Aide (MA).
-There was no documentation of training on the care of a diabetic resident.

Review of a May 2019 electronic Medication Administration Record (eMAR) revealed Staff A had documented she had administered insulin to a resident on 05/02/19, 05/03/19, 05/06/19 -05/08/19, 05/10/19 - 05/13/19, 05/15/19 - 05/17/19, 05/27/19 - 05/28/19, and 05/30/19 - 05/31/19 at 8:00am.

Review of a June 2019 eMAR revealed Staff A had documented she had administered insulin to a resident on 06/03/19, 06/26/19 - 06/28/19, and 06/30/19 at 8:00am.

Review of a July 1 - 2, 2019 eMAR revealed Staff A had documented she had administered insulin to a resident on 07/01/19 - 07/02/19 at 8:00am.

Interview with the Medication Aide on 07/03/19 at 1:57pm revealed:
-She had performed finger stick blood sugar checks and administered insulin to residents.
-She had not received any diabetic care training while employed at the facility.

Refer to the interview with the Health and Wellness Director on 07/03/19 at 10:00am.

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D 164	Continued From page 2	D 164		

Refer to the Business Office Manager (BOM) on 07/03/19 at 11:48am.

Refer to the interview with the Administrator on 07/03/19 at 2:05pm.

2. Review of Staff B's personnel record revealed:
-Staff B was hired 11/20/18 as a Medication Aide (MA).
-There was no documentation of training on the care of a diabetic resident.

Review of a May 2019 electronic Medication Administration Record (eMAR) revealed Staff B had documented she had administered insulin to a resident on 05/02/19, 05/05/19, 05/09/19, 05/16/19, and 05/18/19 at 8:00pm.

Review of a June 2019 eMAR revealed Staff B had documented she had administered insulin to a resident on 06/06/19 and 06/25/19 at 8:00am, and 06/19/19, 06/20/19, and 06/25/19 at 5:00pm.

Observation of the noon medication pass on 07/02/19 at 11:39am - 11:59am revealed Staff B obtained finger stick blood sugars and administered insulin to two residents.

Interview with the Medication Aide on 07/03/19 at 11:22am revealed:
-She administered insulin to residents in the facility.
-She had received diabetic care at a previous facility.
-She had not received any diabetic care training at this facility.

Refer to the interview with the Health and Wellness Director on 07/03/19 at 10:00am.

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D 164	Continued From page 3 Refer to the Business Office Manager (BOM) on 07/03/19 at 11:48am. Refer to the interview with the Administrator on 07/03/19 at 2:05pm. 3. Review of Staff D's personnel record revealed: -Staff D was hired 02/20/18 as a Medication Aide (MA). -There was no documentation of training on the care of a diabetic resident. Review of a May 2019 electronic Medication Administration Record (eMAR) revealed Staff D had documented she had administered insulin to a resident on 05/24/19 at 8:00am and 12:00pm. Review of a June 2019 eMAR revealedStaff D had documented she had administered insulin to a resident on 06/12/19, 06/13/19, 06/17/19, and 06/18/19 at 8:00am. Telephone interview with the Medication Aide on 07/03/19 at 11:18am revealed: -She worked full time as a Medication Aide (MA) on second shift. -She had received diabetic training "one month or six weeks ago" in the facility. Refer to the interview with the Health and Wellness Director on 07/03/19 at 10:00am. Refer to the Business Office Manager (BOM) on 07/03/19 at 11:48am. Refer to the interview with the Administrator on 07/03/19 at 2:05pm. 4. Review of Staff E's personnel record revealed: -Staff E was hired in July 2017 as a Medication	D 164		

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D 164	Continued From page 4 Aide (MA). -There was no documentation of training on the care of a diabetic resident. Review of a May 2019 electronic Medication Administration Recod (eMAR) revealed Staff E had documented she had administered insulin to a resident 05/23/19, 05/25/19, and 05/26/19 at 8:00pm. Review of a June 2019 eMAR revealed Staff E had documented she had administered insulin to a resident 06/01/19, 06/02/19, 06/06/19, 06/07/19, 06/08/19, 06/12/19, 06/14/19, 06/16/19, and 06/17/19 at 5:00pm. Attempted telephone interview with Staff E on 07/03/19 at 11:30am was unsuccessful. Refer to the interview with the Health and Wellness Director on 07/03/19 at 10:00am. Refer to the Business Office Manager (BOM) on 07/03/19 at 11:48am. Refer to the interview with the Administrator on 07/03/19 at 2:05pm. Interview with the Health and Wellness Director on 07/03/19 at 10:00am revealed: -She had been working in the facility for 10 days. -The Medication Aides (MAs) had not received any diabetic training. -She did not know why the MAs had not received the training. Interview with the Business Office Manager (BOM) on 07/03/19 at 11:48am revealed: -She had been hired as the BOM in October 2018.	D 164		

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D 164	Continued From page 5 -She was responsible for ensuring all required documents were in the personnel records. -She had started a "tracking sheet about 2 months ago" on new employee records. -The "new" nurse would be conducting all the training for the MAs. Interview with the Administrator on 07/03/19 at 2:05pm revealed: -The previous facility nurse or a contracted nurse conducted all training for MAs. -She did not know why the MAs had not received the diabetic training. -The BOM was responsible for ensuring all required documents were in the personnel records. The facility failed to ensure all medications aides received training on the care of diabetic residents before administering insulin. This failure placed all diabetic residents at risk of high or low blood glucose levels and 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 07/03/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 17, 2019	D 164		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 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	D 276		

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D 276	Continued From page 6 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 record review, resident and staff interviews the facility failed to implement a physician's order to obtain two ordered blood tests for 1 of 5 residents (#3). The findings are: Review of Resident #3's FL2 dated 02/18/19 revealed diagnoses including diabetes and hyperlipidemia. Review of Resident #3's physician's order dated 03/27/19 revealed orders for the following lab work to be completed: -Complete Blood Count (CBC) - (a blood test that measures the cells in the blood). -A Basic Metabolic Panel (BMP) - (a blood test that reflects the status of a person's metabolism, including health of the kidneys, blood glucose level, and electrolyte and acid/base balance). -A hemoglobin (Hg) - (a blood test which measures the protein which carries oxygen). -A hemoglobin A1C (HgA1C) - (a blood test measures how much of your hemoglobin is coated with sugar). -A lipid panel a blood test measures the amount	D 276		

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D 276	Continued From page 7 of fatty substances in the blood. Review of Resident #3's laboratory completed blood work dated 05/20/19 revealed: -There were results for the CBC, BMP and Hg. -There were no results for a hemoglobin or lipid panel. Interview with Resident #3 on 07/03/19 at 8:46am revealed: -Her last hemoglobin was done before she was admitted to the facility on 02/28/19. -She had a diagnosis of diabetes and received an insulin injection for this daily. -She had high cholesterol and received medication for this daily. An interview with the Resident Care Coordinator (RCC) on 07/03/19 at 9:12am revealed: - The Family Nurse Practitioner (FNP) was at the facility every Tuesday. -The Medical Doctor (MD) was at the facility every Wednesday. -There is a "Doctor's Book" that they look in each time they come to the facility. -Labs should be completed per the physician's order by the next business day. -She would have expected the MD or FNP to have caught that these labs had not been done before now. -She is new to the facility and has only been in her position for 3 weeks. An interview with the Administrator on 07/03/19 at 2:00pm revealed she was not aware the CBC, BMP and Hgb were not drawn timely or that the A1c and lipid panel had yet to be drawn.	D 276		

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D 358	Continued From page 8	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 2 of 6 sampled residents (#6 and #3) related medications for pain, stool softener, iron deficiency and a supplement. The findings are: 1. Review of Resident #6's current FL2 dated 01/03/19 revealed: -Diagnoses included right lower leg cellulitis and osteoarthritis. -There was a medication order for diclofenac sodium (anti-inflammatory used for pain relief) 1% gel apply 4 grams to both knees three times daily.	D 358		

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D 358	Continued From page 9 Observation of the noon medication pass on 07/02/19 at 11:45am - 11:55am revealed: -The Medication Aide (MA) removed a tube, labeled diclofenac sodium 1% gel apply 2 grams to lower right back 4 times daily, and squeezed out the gel into a 30ml medication cup. -"Use the dosing card attached inside the box" was printed on the box of the diclofenac sodium. -The MA was instructed not to use a medication cup because there was a measuring device inside the box. -The MA measured out 2 grams of diclofenac sodium onto the measuring device. -The MA applied the 2 grams of diclofenac sodium onto Resident #6's right and left knees. Interview with the MA on 07/02/19 at 11:47am revealed: -She had been taught by another MA to measure out the diclofenac sodium into a medication cup. -It was easier to put the medication in a cup rather than use the measuring device that was in the diclofenac sodium box. Observation of Resident #6's medications on hand on 07/02/19 at 4:29pm revealed: -There was one 100 gram tube of diclofenac sodium 1% gel with a dispense date of 06/28/19. -Apply 2 grams to lower right back four times daily for back pain was printed on the label. -There was one 100 gram tube of diclofenac sodium 1% gel with a dispense date of 02/21/19. -Apply 4 grams to knees three times daily was printed on the label. -A sticker with a handwritten "2 of 2" was on the label. Interview with Resident #6 on 07/03/19 at 11:20am revealed:	D 358		

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-The staff did administer the diclofenac gel to his knees during the day.
-He was not having any pain in his knees.

Interview with the MA on 07/03/19 at 11:22am revealed she had "looked at the eMAR wrong" and had applied the 2 grams of diclofenac sodium to Resident "6's knees instead of 4 grams.

Review of the May 2019 electronic Medication Administration Record (eMAR) for Resident #6 revealed:
-Diclofenac sodium 1% gel apply 4 grams to knees three times daily was listed on the eMAR with administration times of 9:00am, 2:00pm, and 8:00pm.
-The diclofenac sodium was documented as administered on 05/01/19 -05/07/19, 05/09/19 - 05/11/19, 05/13/19, 05/16/19 - 05/26/19, 05/29/19 - 05/31/19 at 9:00am, 2:00pm, and 8:00pm, and on 05/08/19, 05/12/19, 05/14/19, 05/15,19, 05/27/19 and 05/28/19 at 9:00am and 8:00pm.

Review of the June 2019 eMAR for Resident #6 revealed:
-Diclofenac sodium 1% gel apply 4 grams to knees three times daily was listed on the eMAR with administration times of 9:00am, 2:00pm, 8:00pm.
-The diclofenac sodium was documented as administered on 06/01/19 - 06/08/19, 06/10/19 - 06/13/19, 06/16/19 - 06/22/19, and 06/24/19 - 06/30/19 at 9:00am, 2:00pm and 8:00pm, and 06/09/19, 06/14/19, 06/15/19, and 06/23/19 at 9:00am and 8:00pm.

Review of the July 1 - 2, 2019 electronic Medication Administration Record (eMAR) for Resident #6 revealed:

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-Diclofenac sodium 1% gel apply 4 grams to knees three times daily was listed on the eMAR with administration times of 9:00am, 2:00pm, and 8:00pm.
-The diclofenac sodium 1% gel was documented as administered at 9:00am, 2:00pm, and 8:00pm on 07/01/19 and at 9:00am on 07/02/19.

Telephone interview with a representative from the facility's contracted pharmacy on 07/02/19 at 4:00pm revealed:
-The pharmacy had received an order for Resident #6 for diclofenac sodium 1% gel apply 4 grams to the knees three times daily on 10/18/18.
-A measuring device ruler is included in the box of diclofenac sodium to accurately measure the medication.
-Diclofenac sodium 1% gel 100 grams was dispensed on 10/23/18, 01/08/19, 02/21/19, 02/25/19, 03/29/19, and 06/28/19.

Interview with the Resident Care Coordinator (RCC) on 07/03/19 at 8:56am revealed:
-The measuring device in the diclofenac sodium box should be used to accurately measure the medication.
-The MAs were trained to read the MARs.
-The facility nurse trains the MAs when they are hired.

Interview with the Administrator on 07/03/19 at 2:05pm revealed:
-The facility nurse or a contracted nurse provided training to the MAs.
-The MA should have administered the medications as ordered.

Attempted telephone interview with Resident #6's physician on 07/03/19 at 2:17pm was unsuccessful.

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D 358	Continued From page 12 2. Review of Resident #6's current FL-2 dated 02/18/19 revealed: -Diagnoses included left lower extremity fracture and anemia. -There were medication orders for Cerovite Senior multivitamin one tablet (tab) daily s a supplemnet and Ferrous Sulfate SU 325 milligram (mg) tab daily for anemia. Review of subsequent physician's order dated 05/14/19 for docusate sodium 100 mg softgel (a medication used to soften stool) every night. Observation of Resident #3's medication on hand on 07/03/19 revealed: -The senior multivitamin was not available. -The ferrous sulfate 325 mg tablet was not available. -The docusate sodium 100mg softgel was not available. Record review of the MAR for May 2019 revealed: -Cerovite Senior multivitamin tablet was administered daily at 8:00am. -Docusate Sodium 100mg softgel was administered daily at 9:00pm beginning on 05/21/19. -Ferrous Sulfate tablet was administered daily at 8:00am. Record review of the MAR for June 2019 revealed: -Cerovite Senior multivitamin tablet was administered daily at 8:00am. -Docusate Sodium 100mg softgel was administered daily at 9:00pm. -Ferrous Sulfate tablet was administered daily at	D 358		

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D 358	Continued From page 13 8:00am. Record review of the MAR for July 2019 revealed: -Cerovite Senior multivitamin tablet was administered daily at 8:00am. -Docusate Sodium 100mg softgel was administered daily at 9:00pm. -Ferrous Sulfate tablet was administered daily at 8:00am. Interview with a Medication Aide (MA) on 07/03/19 at 9:04am revealed: -Resident #3's family member purchased some of her medications and brought them to the facility. -She realized the medications brought in by the family member were not the same as what was on the Medication Administration Record (MAR). -She did not know why the MAR was not changed to reflect actual medication being given. -The pharmacy should be contacted if a medication did not match up to the MAR. -The first shift MA who accepted the medications from her family member should have contacted the pharmacy for clarification. -She had never received the medication for Resident #3 that was brought in by her family member. An observation during the interview with the MA on 07/03/19 at 9:04am revealed: -Staff was administering Senna 8.6mg tab every night instead of docusate sodium 100mg softgel. -Staff was administering Iron 27mg tab every morning instead of Ferrous Sulfate 325mg tab. -There was no Cerovite Senior multivitamin available. Interview with the Resident Care Coordinator (RCC) on 07/03/19 at 9:12am revealed: -She was unaware the medications being given	D 358		

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	HAL018024	A. BUILDING: _____ B. WING _____	07/03/2019

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D 358	Continued From page 14 did not match the MAR. -The MA's needed to verify medications brought in by family members were approved by the physician. -The MA's needed to check and make sure it was the same medication on the MAR before administering the medication. -She had just started working in the facility 3 weeks ago and was not aware this was an issue. Interview with a Pharmacy Technician from the facility's contracted pharmacy on 07/03/19 at 9:38am revealed: -The last order for senior multivitamin tabs was a 30-day supply sent on 03/26/19. -The last order for ferrous sulfate tabs was a 30-day supply sent on 04/22/19. -The last order for docusate sodium 100mg softgels was a 30-day supply sent on 06/06/19. Interview with the Administrator on 07/03/19 at 2:00pm revealed she was unaware medications were not being administered per the physician's order.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of	D 367		

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D 367	Continued From page 15 medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to assure the accuracy of the Medication Administration Record (MAR) for 1 of 5 Residents (#3) reviewed. The findings are: Record review of Resident #6's current FL-2 dated 02/18/19 revealed: -Diagnoses included left lower extremity fracture and anemia. -There were medication orders for Cerovite Senior multivitamin one tablet (tab) by mouth daily and Ferrous Sulfate SU 325 milligram (mg) tab by mouth daily. Record review revealed an additional physician's order dated 05/14/19 for Docusate Sodium 100 mg softgel by mouth every night. Observation of Resident #3's medication on hand	D 367		

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D 367	Continued From page 16 on 07/03/19 revealed: -Cerovite Senior multivitamin tab was not available. -Ferrous Sulfate 325 mg tab was not available. -Docusate Sodium 100mg softgel was not available. Interview with the Medication Aide (MA) on 07/03/19 at 9:04am revealed: -Resident #3's family member purchases some of her medications and brings them to the facility. -Senna 8.6mg tab by mouth every night was being used instead of Docusate Sodium 100mg softgel. -Iron 27mg tab by mouth every morning in being used instead of Ferrous Sulfate 325mg tab. -She had already administered her Iron 27mg tab this morning. -There was no Cerovite Senior multivitamin tab available. -She realized the medications brought in by the family member did not match what was on the MAR. -She did not know why the MAR was not changed to reflect actual medication being given. -The pharmacy should be contacted if a medication does not match up to the MAR. -Whoever the first shift MA was that accepted the medications from her family member should be contacting the pharmacy for clarification. -She had never received the medication for Resident #3 that was brought in by her family member. Record review of the MAR for May 2019 revealed: -Cerovite Senior multivitamin tablet was administered daily at 8:00am. -Docusate Sodium 100mg softgel was administered daily at 9:00pm beginning on	D 367		

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D 367	Continued From page 17	D 367		

05/21/19.
-Ferrous Sulfate tablet was administered daily at 8:00am.

Record review of the MAR for June 2019 revealed:
-Cerovite Senior multivitamin tablet was administered daily at 8:00am.
-Docusate Sodium 100mg softgel was administered daily at 9:00pm.
-Ferrous Sulfate tablet was administered daily at 8:00am.

Record review of the MAR for July 2019 revealed:
-Cerovite Senior multivitamin tablet was administered daily at 8:00am.
-Docusate Sodium 100mg softgel was administered daily at 9:00pm.
-Ferrous Sulfate tablet was administered daily at 8:00am.

Interview with the Resident Care Coordinator (RCC) on 07/03/19 at 9:12am revealed:
-She was unaware the medications admnistered did not match the MAR.
-The MA needed to verify medications brought in by family members were ok to administer per the physician.
-They needed to check and make sure it was the same medication on the MAR before administering the medication.

Interview with the Pharmacy Technician on 07/03/19 at 9:38am revealed:
-The last order for Cerovite Senior multivitamin tabs was a 30-day supply sent on 03/26/19.
-The last order for Ferrous Sulfate tabs was a 30-day supply sent on 04/22/19.
-The last order for Docusate Sodium 100mg softgels was a 30-day supply sent on 06/06/19.

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D 367	Continued From page 18 Interview with the Administrator on 07/03/19 at 2:00pm revealed: -She was unaware medications signed off on the MAR as administered were not the actual medications being administered to Resident #3. Attempts made to contact the facility physician were unsuccessful.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that medications were administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents related to 2 of 2 Medication Aides (Staff A and B) not using appropriate hand hygiene techniques and not wearing gloves when administering eye drops. The findings are: 1. Observation of the noon medication pass on	D 371		

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D 371	Continued From page 19	D 371		

07/02/19 at 11:39am to 11:59am revealed:
-The Staff B applied gloves, performed a blood glucose level check and administered insulin to one resident, and removed her gloves.
-She did not use hand sanitizer or wash her hands.
-She then applied gloves, administered a topical medication to a second resident, and removed the gloves.
-She did not use hand sanitizer or wash her hands.
-She then applied gloves, performed a blood glucose level check and administered insulin to a third resident, and removed the gloves.
-She did not use hand sanitizer or wash her hands.

Interview with Staff B on 07/02/19 at 12:13pm revealed:
-She had not used hand sanitizer or washed her hands between glove changes because she did not have any hand sanitizer on the medication cart and was "a little nervous".
-She had not received any infection control training in the facility.

2. Observation of the morning medication pass on 07/03/19 at 7:56am revealed:
-The Staff A administered one eye drop into each of one resident's eyes.
-She did not immediately wash hands or use hand sanitizer before administering the eye drops.
-She was not wear gloves when she administered the eye drops.

Interview with the MA on 07/03/19 at 7:58am revealed:
-She had not worn gloves when administering the eye drops because she had no physical contact

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D 371	Continued From page 20 with the eye. -She "probably" had infection control training "last year". Interview with the Health and Wellness Director on 07/02/19 at 3:58pm revealed: -She did not know what infection control training the staff had received. -She knew the staff were required to have yearly infection control training. Interview with the Administrator on 07/03/19 at 2:05pm revealed: -The previous facility nurse or a contracted nurse provided staff with infection control training. -She did not know why the MAs had not received the required infection control training.	D 371		
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, record reviews, and interviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations in the areas of training on the care of diabetic	D912		

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D912	Continued From page 21 residents, infection prevention requirements and medication aides training and competency. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure 4 of 4 sampled Medication Aides (Staff A, B, D, and E) who administered insulin and performed finger stick blood sugars checks for residents completed training on the care of diabetic residents prior to the administration of insulin. [Refer to Tag 164 10A NCAC 13F .0505 Training on the Care of a Diabetic Resident (Type B Violation.)] 2. Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 4 sampled Medication Aides (Staff A, D, and E), who had been employed at least one year, completed the state-mandated infection control training annually. [Refer to Tag 934 G.S. 131D-4.5(B)(a) Ach Infection Prevention Requirements (Type B Violation.)] 3. Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 4 sampled staff (Staff B, D, and E) who administered medications, had employment verification or had completed the 5, 10, or 15-hour medication administration training course. [Refer to Tag 935 G.S. 131D-4.5(B)(b) Ach Medication Aides: Training and Competency (Type B Violation).]	D912		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection	D934		

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D934	Continued From page 22 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 observations, interviews, and record reviews, the facility failed to ensure 3 of 4 sampled Medication Aides (Staff A, D, and E), who had been employed at least one year, completed the state-mandated infection control training annually. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired as a Medication Aide (MA) March 2016. -There was no documentation that Staff A completed the yearly state-mandated infection	D934		

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D934	Continued From page 23 control training. Observation of the morning medication pass on 07/03/19 at 7:56am revealed: -Staff A administered one eye drop into each of one resident's eyes. -Staff A did not immediately wash hands before administering the eye drops or wear gloves. Interview with Staff A on 07/03/19 at 7:58am revealed: -She had not worn gloves when administering the eye drops because she had no physical contact with the eye. -She "probably" had infection control training "last year". Refer to the interview with the Health and Wellness Director (HWD) on 07/03/19 at 10:00am. Refer to the interview with the Business Office Manager (BOM) on 07/03/19 at 11:48am. Refer to the telephone interview with the Administrator on 07/03/19 at 2:05pm. 2. Review of Staff D's personnel record revealed: -Staff D was hired as a Medication Aide (MA) 02/20/18. -There was no documentation that Staff D completed the yearly state-mandated infection control training. Telephone interview with Staff D on 07/03/19 at 11:18 am revealed: -She worked full time as a Medication Aide on second shift. -She did not know if she had ever received infection control training.	D934		

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D934	Continued From page 24 Refer to the interview with the Health and Wellness Director (HWD) on 07/03/19 at 10:00am. Refer to the interview with the Business Office Manager (BOM) on 07/03/19 at 11:48am. Refer to the telephone interview with the Administrator on 07/03/19 at 2:05pm. 3. Review of Staff E's personnel record revealed: -Staff E was hired as a Medication Aide (MA) July 2017. -There was no documentation that Staff E completed the yearly state-mandated infection control training. Attempted telephone interview with Staff E on 07/03/19 at 11:30am was unsuccessful. Refer to the interview with the Health and Wellness Director (HWD) on 07/03/19 at 10:00am. Refer to the interview with the Business Office Manager (BOM) on 07/03/19 at 11:48am. Refer to the telephone interview with the Administrator on 07/03/19 at 2:05pm. Interview with the Health and Wellness Director (HWD) on 07/03/19 at 10:00am revealed: -She knew the MAs were required to receive an annual infection control training. -She did not know why the MAs had not received the annual infection control training. -She knew there were two residents in isolation for bacterial infections.	D934		

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D934	Continued From page 25 Interview with the Business Office Manager (BOM) on 07/03/19 at 11:48am revealed: -She had been hired as the BOM in October 2018. -She was responsible for ensuring all required documents were in the personnel records. -She had started a "tracking sheet about 2 months ago" on new employee records. -The "new" nurse would be conducting all the training for the MAs. Telephone interview with the Administrator on 07/03/19 at 2:05pm revealed: -The previous facility nurse or a contracted nurse conducted all training for MAs. -She knew the MAs were required to receive annual infection control training. -She did not know why the MAs had not received the training. -The Business Office Manager (BOM) was responsible for ensuring all required documents were in the personnel files. The facility failed to provide the state mandated annual infection control training to 3 of 4 sampled medication aides. This failure placed all residents at risk of a contracting a bacterial or viral infection and 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 07/03/19 for this violation. CORRECTION DATE FOR THIS VIOLATION SHALL NOT EXCEED AUGUST 17, 2019.	D934		

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D935	Continued From page 26	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding 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	D935		

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D935	Continued From page 27 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 observations, interviews, and record reviews, the facility failed to ensure 3 of 4 sampled staff (Staff B, D, and E) who administered medications, had employment verification or had completed the 5, 10, or 15-hour medication administration training course. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired as a Medication Aide (MA) 11/20/18. -There was documentation Staff B had passed the medication aide exam on 07/10/18. -There was documentation Staff B had completed the medication clinical skills checklist on 11/20/18. -There was no documentation of prior employment verification or that the 5, 10 or 15-hour medication training course had been completed. Observation of the noon medication pass on 07/02/19 from 11:30am to 11:59am revealed: -At 11:30am Staff B administered 7 units of	D935		

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	HAL018024	A. BUILDING: _____ B. WING _____	07/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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insulin (medication to lower blood glucose) to a resident.
-At 11:55am Staff B administered 2 grams of diclofenac sodium 1% gel (anti-inflammatory medication) to a second resident's knees.
-At 11:59am Staff B administered 25 units of insulin to a third resident.

Review of a May 2019 electronic Medication Administration Record (eMAR) revealed Staff B had documented she had administered medications to a resident on 05/02/19, 05/05/19, 05/09/19, 05/16/19, 05/25/19, and 05/26/19 at 4:30pm.

Review of a June 2019 eMAR revealed Staff B had documented she had administered medications to a resident on 06/06/19 and 06/25/19 at 8:00am, and 06/19/19, 06/20/19, and 06/25/19 at 5:00pm.

Interview with Staff B on 07/03/19 at 11:22am revealed:
-She had taken the 15 hour medication course at a previous facility.
-She did not know where the paperwork was.
-The facility had not asked her for the paperwork.

Refer to the interview with the Health and Wellness Director on 07/03/19 at 10:00am.

Refer to the interview with the Business Office Manager (BOM) on 07/03/19 at 11:48am.

Refer to the telephone interview with the Administrator on 07/03/19 at 2:05pm.

2. Review of Staff D's personnel record revealed:
-Staff D was hired as a Medication Aide (MA) 02/20/18.

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D935	Continued From page 29	D935		

-There was documentation Staff D had passed the medication aide exam on 11/05/13.
-There was documentation Staff D had completed the medication clinical skills checklist on 02/21/18.
-There was no documentation of prior employment verification or that the 5, 10 or 15-hour medication training course had been completed.

Review of a May 2019 electronic Medication Administration Record (eMAR) revealed Staff D had documented she had administered medications to a resident on 05/24/19 at 8:00am and 12:00pm.

Review of a June 2019 eMAR revealed Staff D had documented she had administered medications to a resident on 06/12/19, 06/13/19, 06/17/19, and 06/18/19 at 8:00am.

Telephone interview with Staff D on 07/03/19 at 11:18am revealed:
-She worked full time as a Medication Aide on second shift.
-She did not know about the training.

Refer to the interview with the Health and Wellness Director on 07/03/19 at 10:00am.

Refer to the interview with the Business Office Manager (BOM) on 07/03/19 at 11:48am.

Refer to the telephone interview with the Administrator on 07/03/19 at 2:05pm.

3. Review of Staff E's personnel record revealed:
-Staff E was hired as a Medication Aide (MA) July 2017.
-There was documentation Staff E had passed

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D935	Continued From page 30 the medication aide exam on 12/13/16. -There was documentation Staff D had completed the medication clinical skills checklist on 07/26/17. -There was no documentation of prior employment verification or that the 5, 10 or 15-hour medication training course had been completed. Review of a May 2019 electronic Medication Administration Recod (eMAR) revealed Staff E had documented she had administered medications to a resident 05/23/19, 05/25/19, and 05/26/19 at 8:00pm. Review of a June 2019 eMAR revealed Staff E had documented she had administered medications to a resident 06/01/19, 06/02/19, 06/06/19, 06/07/19, 06/08/19, 06/12/19, 06/14/19, 06/16/19, and 06/17/19 at 5:00pm. Attempted telephone interview with Staff E on 07/03/19 at 11:30am was unsuccessful. Refer to the interview with the Health and Wellness Director on 07/03/19 at 10:00am. Refer to the interview with the Business Office Manager (BOM) on 07/03/19 at 11:48am. Refer to the telephone interview with the Administrator on 07/03/19 at 2:05pm. Interview with the Health and Wellness Director on 07/03/19 at 10:00am revealed: -She had been working in the facility for 10 days. -She knew the Medication Aides (MAs) were required to have 15 hours of MA training. -She did not know why the MAs had not received the training.	D935		

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D935	Continued From page 31 Interview with the Business Office Manager (BOM) on 07/03/19 at 11:48am revealed: -She had been hired as the BOM in October 2018. -She was responsible for ensuring all required documents were in the personnel records. -She had started a "tracking sheet about 2 months ago" on new employee records. -The "new" nurse would be conducting all the training for the MAs. Telephone interview with the Administrator on 07/03/19 at 2:05pm revealed: -The previous facility nurse or a contracted nurse conducted all training for MAs. -She did not know why the MAs had not received the 15 hours of MA training. -The BOM was responsible for ensuring all required documents were in the personnel records. The facility failed to ensure Staff B, D, and E, who administered medications to the residents, had obtained the required training for medication administration. This failure placed all residents at risk of medication errors which 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 07/03/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 17, 2019	D935		