STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	R 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 and follow-up survey on 07/24/19-07/25/19.	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 ensure 2 of 4 sampled staff (Staff A and Staff B) were tested for tuberculosis (TB) disease upon hire. The findings are: 1. Review of Staff A's, Medication Aide (MA) personnel record revealed: -Staff A was hired on 02/25/19. -There was documentation of a TB skin test placed on 02/16/18 and read as negative dated 02/19/18. -There was no additional documentation of a TB skin test in Staff A's personnel record. Interview with the Resident Care Coordinator	D 131		

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D 131	Continued From page 1 (RCC) on 07/25/19 at 3:40 pm revealed she did not know Staff A did not have a TB skin test completed upon hire. Interview with the Executive Director (ED) on 07/25/19 at 3:55 pm revealed: -She did not know Staff A did not have a TB skin test completed upon hire. -Staff A needed the first TB skin test prior to working in the facility and the second TB skin test two to three weeks after employment. Interview with the Management Liaison on 07/25/19 at 3:55 pm revealed she did not know Staff A did not have a TB skin test completed upon hire. Attempted telephone interview with Staff A on 07/25/19 at 3:11 pm was unsuccessful. Based on an interview with the Executive Director, the Office Manager was unavailable for interviews on 07/24/19 and 07/25/19. Refer to interview with the RCC on 07/25/19 at 3:40 pm. Refer to the interview with the ED on 07/25/19 at 3:55 pm. Refer to the interview with the Management Liaison on 07/25/19 at 3:55 pm. 2. Review of Staff B's, Personal Care Aide (PCA) personnel record revealed: -Staff B was hired on 06/14/19. -There was documentation of a TB skin test placed 02/16/18 read as negative dated 02/19/18. -There was no additional documentation of a TB skin test in Staff B's personnel record.	D 131		

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D 131	Continued From page 2 Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 3:40 pm revealed she did not know that Staff B did not have a TB skin test completed upon hire. Interview with the Executive Director (ED) on 07/25/19 at 3:55 pm revealed: -Staff B did not have a TB skin test completed upon hire. -Staff B needed the first TB skin test prior to working in the facility and the second TB skin test two to three weeks after employment. Interview with the Management Liaison on 07/25/19 at 3:55 pm revealed she did not know Staff B did not have a TB skin test completed upon hire. Telephone interview with Staff B on 07/25/19 at 3:26 pm revealed: -She had the first TB skin test administered in August 2018 and the results were negative. -She did not complete a second TB skin test because she left the facility and was employed for approximately four months. -She did not know that she had to get a new TB skin test upon re-hire. -She was informed by the Office Manager that she only needed a second TB skin test. -The Office Manager was responsible for informing staff of a TB skin test upon hire. -She did not know who was responsible for ensuring all staff completed a TB skin test upon hire. Based on an interview with the Executive Director, the Office Manager was unavailable for interviews on 07/24/19 and 07/25/19.	D 131		

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D 131	Continued From page 3 Refer to interview with the RCC on 07/25/19 at 3:40 pm. Refer to the interview with the ED on 07/25/19 at 3:55 pm. Refer to the interview with the Management Liaison on 07/25/19 at 3:55 pm. Interview with the RCC on 07/25/19 at 3:40 pm revealed: -She knew all staff needed a TB skin test prior to working in the facility and the second TB skin test two weeks after employment. -The Office Manager was responsible for assuring staff had a TB skin test completed upon hire. -The ED was responsible for performing personnel record audits. -She did not perform personnel record audits. Interview with the ED on 07/25/19 at 3:55 pm revealed: -The Office Manager was responsible for assuring all staff had a TB skin test completed at hire. -The Office Manager was responsible for completing personnel records and performing personnel record audits at random. Interview with the Management Liaison on 07/25/19 at 3:55 pm revealed: -The personnel records were electronic and stored on a computer. -The Office Manager was the only on-site staff with access to the personnel records and she was out of the office. -The ED did not have access to the virtual personnel records.	D 131		

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D 131	Continued From page 4 The facility failed to assure 2 of 4 sampled staff (Staff A and B) were tested for tuberculosis disease which increased the risk of the transmission of TB disease. 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 07/25/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 8, 2019.	D 131		
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 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:	D 161		

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D 161	Continued From page 5 Based on record reviews and interviews, the facility failed to assure 1 of 4 sampled staff (Staff A) was competency validated by a Registered Nurse with return demonstration prior to performing Licensed Health Professional Support (LHPS) tasks of finger stick blood sugars and medication administration through injection. The findings are: Review of Staff A's, Medication Aide (MA) personnel record revealed: -Staff A was hired on 02/25/19. -There was no documentation an LHPS competency validation had been completed. Review of the July 2019 electronic Medication Administration Record (eMAR) of residents with orders for fingerstick blood sugars and insulin injections revealed documentation Staff A administered insulin and checked fingerstick blood sugars 11 out of 24 days. Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 3:40 pm revealed: -She did not know that Staff A's LHPS competency validation was not in the personnel record. -The RCC was responsible for LHPS competency validation. -The LHPS validation included five days of training on the floor, then a skills check-off. -She did not perform personnel record audits. Interview with the Executive Director (ED) on 07/25/19 at 3:55 pm revealed: -She did not know that Staff A's LHPS competency validation was not in the personnel record. -The Office Manager was responsible for	D 161		

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D 161	Continued From page 6 assuring staff were LHPS competency validated. -The LHPS competency validation was completed after five days of training and then a Registered Nurse completed a skills check-off. -The Office Manager was responsible for completing personnel records and performing record audits at random. Interview with the Management Liaison on 07/25/19 at 3:55 pm revealed: -She did not know that Staff A's LHPS competency validation was not in the personnel record. -The personnel records were electronic and stored on a computer. -Human Resources was ultimately responsible for maintaining personnel records. -The Office Manager was the only on-site staff with access to the records and she was out of the office. -She requested and was granted access to the virtual personnel records and she could not locate the LHPS competency validation for Staff A. Attempted telephone interview with Staff A on 07/25/19 at 3:11 pm was unsuccessful. Based on an interview with the Executive Director, the Office Manager was unavailable for interviews on 07/24/19 and 07/25/19.	D 161		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.	D 296		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic menu for 1 of 5 sampled residents (Resident #4) with a physician's order for a Consistent Carbohydrate Diet (CCHO).

The findings are:

Observation of the kitchen on 07/24/19 at 10:15 am revealed there was a therapeutic menu and a resident diet list available.

Review of Resident #2's current FL-2 dated 03/29/19 revealed:
-Diagnoses included pneumonia, exacerbation of chronic obstructive pulmonary disease, acute and chronic hypoxia, left hand pain, type II diabetes, and hypertension.
-Resident #2 was ordered a CCHO diet (minced and moist) with thin liquids.

Review of the therapeutic diet list dated 07/19/19 revealed Resident #2 was to be served a No Concentrated Sweets (NCS) diet.

Review of the facility menus revealed there was no therapeutic menu for a CCHO diet.

Review of Week 3 Day 4 lunch menu revealed mesquite roasted turkey, sage bread dressing, turkey gravy, buttered green beans, wheat dinner roll/bread, margarine, cheesecake with cherry topping, and beverage of choice.

Observation of the lunch meal service on 07/24/19 from 12:15 pm through 1:15 pm

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revealed:
-Resident #2 was served mesquite roasted turkey, sage bread dressing, turkey gravy, buttered green peas, and apples.
-Resident #2 consumed 100% of the meal without difficulty.

Interview with a personal care aide (PCA) on 07/25/19 at 11:40 am revealed:
-The cook prepared the plates according to the resident diet list in the kitchen and then staff delivered the plates to the residents.
-The cook told the staff which resident each plate was assigned to.
-She did not know if Resident #2 was on a special diet.
-The facility had a cook during the week and another cook on the weekends.

Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 3:40 pm revealed:
-She had been the RCC since 07/05/19.
-She was not sure who updated the diet list in the kitchen.
-She did not know Resident #2 was ordered a CCHO diet.

Telephone interview with the Administrator on 07/25/19 at 11:45 am revealed:
-The Administrator and the RCC were responsible for updating the diet orders with the kitchen staff and advise staff of any changes.
-She did not know the diet list in the kitchen was incorrect.
-She would have expected the CCHO diet to be clarified.
-The CCHO diet was clarified by the physician on 07/25/19 and the current order was for NCS.

Interview with the Management Liaison on

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D 296	Continued From page 9 07/25/19 at 11:50 am revealed: -The RCC was currently responsible for order clarification. -The physician clarified the diet order for NCS on 07/25/19. -The RCC/Supervisor was responsible for updating the kitchen of new/changed diet orders. Interview with the facility cook on 07/25/19 at 3:30 pm revealed: -She prepared meals by the dietary list provided in the kitchen. -She did not know who updated the dietary list in the kitchen. -She did not know Resident #2 was ordered a CCHO diet. Attempted interview with Resident #2's Primary Care Physician on 07/25/19 at 11:00 am was unsuccessful. Attempted interview with a second facility cook on 07/25/19 at 3:25 pm was unsuccessful.	D 296		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.	D 315		

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D 315	Continued From page 10 This Rule is not met as evidenced by: Based on observations, interviews, and review of the facility's activity calendar, the facility failed to develop and implement an activity program that promoted active involvement of the residents. The findings are: Observation of the facility on 07/24/19 revealed there was no activity calendar was posted. Observation on 07/24/19 at 9:40 am the activities room revealed the activity room was open for residents and supplies (coloring books and games) were available. Interview with a resident on 07/24/19 at 9:45 am revealed: -The facility did not have an Activity Director. -She enjoyed playing bingo, but the facility did not offer bingo often. -On Sundays she attended church services offered at the facility. Interview with a second resident on 07/24/19 at 9:53 am revealed: -There were "no activities offered unless you counted smoking and visiting the doctor." -There had not been an Activity Director since the end of February 2019. Interview with a third resident on 07/24/19 at 10:00 am revealed no activities were offered. Interview with a fourth resident on 07/24/19 at 10:40 am revealed: -There had not been an Activity Director since the end of February 2019. -The residents had noting to do. "Their minds were not being occupied or	D 315		

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stimulated".

Interview with a personal care aide (PCA) on 07/25/19 at 11:40 am revealed:
-She had come in on days off to provide activities such as bingo for the residents.
-The facility had been without an Activity Director for at least 2-3 months.
-An activity calendar had not been posted since the Activity Director left.
-When an activity calendar was posted the staff followed the schedule.
-With no activity calendar posted the staff provided activities when they had time.
-The facility provided coloring, bingo, bowling, and church activities.

Interview with the Executive Director (ED) on 07/25/19 at 11:45 am revealed:
-The Activity Director resigned as of 06/09/19.
-Staff assisted with board games and bingo.
-When she started as the ED in June 2019 there was a May 2019 calendar posted.
-She removed the out dated activity calendar and a new calendar was not posted.
-Staff provided 3-4 activities everyday.
-No activities were provided on 07/24/19.
-She knew an activity calendar was supposed to be posted with at least 14 hours per week posted.

Interview with the Management Liaison on 07/25/19 at 11:50 am revealed:
-The facility did not have an Activity Director but she did not know the date of her resignation.
-The facility was currently looking for a part time Activity Director.
-She did not know an activity calendar was not posted.
-Staff were providing activities for residents such as coloring, bingo, and church activities were

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D 315	Continued From page 12 available. -She knew an activity calendar was supposed to be posted for each month with at least 14 hours per week scheduled. Observation of the facility on 07/24/19 and 07/25/19 revealed no activities were provided for residents.	D 315		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to test for tuberculosis. The findings are: Based on interviews and record reviews, the facility failed to ensure 2 of 4 sampled staff (Staff A and Staff B) were tested for tuberculosis (TB) disease upon hire. [Refer to Tag 0131, 10A NCAC 13F. 0406(a) Test For Tuberculosis (Type B Violation)].	D912		

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D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 4 staff sampled (Staff C) who had been working for a least a year as a Medication Aide (MA) received the annual state approved infection control training. The findings are: Review of Staff C's, MA personnel record revealed: -Staff C was hired on 02/14/17. -There was no documentation for completion of the annual state approved infection control	D934		

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D934	Continued From page 14 training. Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 3:40 pm revealed: -She did not know that Staff C did not have documentation of completion of the annual state approved infection control training in the personnel record. -She knew a state approved infection control training was scheduled for August 2019, but she did not know who set up the class. Interview with the Executive Director (ED) on 07/25/19 at 3:55 pm revealed: -She did not know that Staff C did not have documentation of completion of the annual state approved infection control training in the personnel record. -She was responsible for scheduling the annual state approved infection control training. -The next state approved infection control training was scheduled for August 2019. -Staff C was on the list to attend the state approved infection control training scheduled for August 2019. -The Office Manager was responsible for completing personnel records and performing personnel record audits at random. Interview with the Management Liaison on 07/25/19 at 3:55 pm revealed: -She did not know that Staff C did not have documentation of completion of the annual state approved infection control training in the personnel record. -The personnel records were electronic and stored on a computer. -Human Resources was ultimately responsible for maintaining personnel records.	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	R 07/25/2019

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ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

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D934	Continued From page 15 Attempted telephone interview with Staff C on 07/25/19 at 3:15 pm was unsuccessful. Based on an interview with the Executive Director, the Office Manager was unavailable for interviews on 07/24/19 and 07/25/19.	D934		
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:	D935		

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D935	Continued From page 16 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 4 sampled staff (Staff A) who administered medications, had completed the Medication Clinical Skills Competency validation and the 5, 10, or 15 hour state approved medication training prior to administering medications. The findings are: Review of Staff A's, medication aide (MA) personnel record revealed: -Staff A was hired 02/25/19 as a medication aide. -There was documentation Staff A completed the Medication Clinical Skills Competency validation on 03/07/19. -There was documentation Staff A passed the written medication administration examination on 11/06/13. -There was incomplete documentation of Facility Medication Aide Verification with the only date of	D935		

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D935	Continued From page 17	D935		

qualified work on 07/31/18.
-There was no documentation of employment verification showing Staff A worked as a medication aide within the past 24 months prior to 07/31/18.
-There was no documentation Staff A completed the 5,10, or 15 hour medication aide training.

Review of a residents' July 2019 medication administration records (MARs) revealed Staff A documented administration of medications 11 out of 24 days.

Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 3:40 pm revealed:
-She did not know that Staff A's Facility Medication Aide Verification documentation was incomplete.
-She was employed as RCC after Staff A was hired.
-The RCC and Executive Director were responsible for ensuring the Medication Clinical Skills Competency Verification competency validation was complete.
-She did not perform personnel record audits.

Interview with the Executive Director (ED) on 07/25/19 at 3:55 pm revealed:
-She did not know that Staff A's Facility Medication Aide Verification documentation was incomplete.
-She was responsible for assuring all MA's had the appropriate training.
-The Office Manager was responsible for completing personnel records and performing personnel record audits at random.

Interview with the Management Liaison on 07/25/19 at 3:55 pm revealed:
-She did not know that Staff A's Facility

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D935	Continued From page 18 Medication Aide Verification documentation was incomplete. -The ED was responsible for assuring all MA's had the appropriate training. -The personnel records were electronic and stored on a computer. -Human Resources was ultimately responsible for maintaining personnel records. Attempted telephone interview with Staff A on 07/25/19 at 3:11 pm was unsuccessful. Based on an interview with the Executive Director, the Office Manager was unavailable for interviews on 07/24/19 and 07/25/19.	D935		