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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on February 5, 2020, through February 6, 2020. | D 000 | | |
| D 022 | 10A NCAC 13G .0214 Suspension Of Admission<br><br>10A NCAC 13G .0214 Suspension Of Admission<br><br>(a) Either the Secretary or his designee shall notify the domiciliary home by certified mail of the decision to suspend admissions. Such notice will include:<br>(1) the period of the suspension,<br>(2) factual allegations,<br>(3) citation of statutes and rules alleged to be violated,<br>(4) notice of the facility's right to contested case hearing or the suspension.<br>(b) The suspension will be effective when the notice is served or on the date specified in the notice of suspension, whichever is later. The suspension will remain effective for the period specified in the notice or until the facility demonstrates to the Secretary or his designee that conditions are no longer detrimental to the health and safety of the residents.<br>(c) The home shall not admit new residents during the effective date of the suspension.<br>(d) Any action taken by the Division of Facility Services to revoke a home's license or to reduce the license to a provisional license shall be accompanied by a recommendation to the Secretary or his designee to suspend new admissions. A suspension may be ordered without the license being affected. | D 022 | | |

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| D 022 | Continued From page 1<br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to comply with Suspension of Admissions (SOA) licensure action dated 11/05/19 as evidenced by the admssion of one resident into the facility after the SOA was in effect.<br><br>The findings are:<br><br>Review of Resident #3's current FL-2 dated 01/09/20 revealed:<br>-Diagnoses included unspecified cerebral infarction, acute chronic systolic heart failure, ischemic cardiomyopathy, unspecified gout, essential primary hypertension, and chronic kidney disease - stage III.<br>-His level of care was recommended as rest home.<br><br>Review of the facility's most current census report dated 02/05/20 revealed Resident #3 was admitted to the facility on 02/03/20.<br><br>Interview with a Supervisor on 02/05/20 at 10:30am revealed Resident #3 was admitted to the facility on 02/03/20 and she assisted the Administrator with his admission.<br><br>Second interview with the same Supervisor on 02/05/20 at 12:05pm revealed:<br>-She did not know the facility was under a SOA.<br>-The Administrator was responsible to handle anything related to a SOA.<br><br>Interview with the Administrator on 02/05/20 at 12:08pm revealed:<br>-She knew the facility was under SOA since November 2019 for failure to submit the facility's cost reports. | D 022 | | |

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| D 022 | Continued From page 2<br>-She did not consider Resident #3 as an admission to the facility.<br>-She "had taken" Resident #3 into the facility on a thirty-day trial basis "to see if he was a good fit for the facility".<br>-She considered Resident #3 "to be in hospice/respite care at the facility" instead of an actual admission to the facility.<br>-Resident #3 had been placed on the facility's census report to show he was in the building and not as an admission to the facility. | D 022 | | |
| D 056 | 10A NCAC 13F .0305(f)(4) Physical Environment<br><br>10A NCAC 13F .0305 Physical Environment<br>(f) The requirements for storage rooms and closets are:<br>(4) Housekeeping storage requirements are:<br>(A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and<br>(B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use;<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to assure cleaners, disinfectants, bleach, laundry detergent, fabric softener, and odor eliminators were stored in locked areas of the facility resulting in hazardous chemicals being unattended and accessible to residents.<br><br>The findings are:<br><br>Observation of the laundry room on 02/05/20 at 10:50am revealed: | D 056 | | |

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| D 056 | Continued From page 3<br>-The laundry room had two exit doors that were both opened.<br>-One laundry room exit door opened into the center hallway next to the Administrator's office and was accessible to the residents.<br>-The second laundry room exit door opened into the rigth hallway leading to the residents' rooms and was accessible to residents.<br>-Both doors were equipped with locks but the locks were not engaged.<br>-There was a cleaning cart inside the opening of the second laundry room exit door with a spray bottle of bathroom cleaner and a spray bottle of odor eliminator on top of the cleaning cart.<br>-A resident in a wheelchair passed by the unsecured laundry exit door and cleaning cart from the right hallway.<br>-There was a four-tier metal rack against the right wall next to the washing machine in the laundry room.<br>-There was a can of furniture polish, a can of disinfectant, and a half gallon bottle of odor eliminator on the bottom rack.<br>-There was a box of dryer sheets, two bottles of disinfecting wipes, a half-gallon bottle of carpet cleaner, a bottle of stain remover, and an unlabeled spray bottle that was one third full of a clear liquid on the second rack.<br>-There was a spray bottle of bleach cleaner, a spray bottle of window cleaner, two cans of carpet deodorizer, a spray bottle of bathroom cleaner, two spray bottles of disinfectants, and an unlabeled spray bottle that was two thirds full of an orange colored liquid, and and unlabeled spray bottle that was two thirds fluid of a clear liquid on the third rack.<br>-There was a can of scouring powder, two bottles of laundry detergent enhancers, and two bottles of stain remover on the fourth rack.<br>-There was a second metal rack next to the dryer | D 056 | | |

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that contained a gallon of bleach, a gallon and half container of laundry detergent, two gallons of stain remover, two gallons of odor eliminator, a 12-ounce tub of cleaning enhancer, and a 16-ounce bottle of laundry detergent.
-There was a 12-pound tub of laundry detergent, a 64-ounce bottle of liquid laundry detergent, a gallon of fabric softener, and a 7-pound box of powdered stain remover on the floor under the metal rack.

Second observation of the laundry room on 02/05/20 at 12:05pm revealed:
-Both laundry room exit doors were still open and the cleaning products inside the laundry room remained unsecured.
-The cleaning cart was still inside the opening of the second laundry room exit door with a spray bottle of bathroom cleaner, a spray bottle of odor eliminator, and a spray bottle of disinfectant were on top of the cleaning cart.

Interview with a Supervisor on 02/05/20 at 12:05pm revealed:
-The laundry room doors were usually kept open when staff did laundry.
-There had never been a problem with residents going inside the laundry room and bothering any items inside the laundry room when the doors were opened.
-The laundry room doors could be locked if needed.
-The cleaning products should have not been left unattended on the cleaning cart.
-The staff worked together to clean the residents' rooms and the cleaning products were left out by accident.

Interview with the Administrator on 02/05/20 at 12:10pm revealed:

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-The laundry room exit doors were kept opened when the staff did the residents' laundry because it was convenient.
-The staff did laundry for the residents daily at the facility.
-The laundry room doors were equipped with locks and could be locked if it was needed.
-It was an oversight that cleaning products were left on the cleaning cart.

Third observation of the laundry room on 02/05/20 at 12:20pm revealed both laundry room exit doors were closed and locked and the cleaning cart was locked inside the laundry room.

Observation of the pantry on 02/05/20 at 5:16pm revealed:
-The door to the pantry was not locked.
-There was a quart of fabric freshener stored on third rack shelf.
-There was a gallon of disinfectant stored on third rack shelf.
-There were two 17.5 fluid oz cans of bug spray stored on the rack.
-There was a 185-fluid oz jug of laundry detergent on the bottom rack shelf.
-There was a 1 gallon of carpet cleaner on the bottom shelf rack
-There was a 32-fluid oz bottle of bathroom cleaner on the bottom rack shelf.
-There was an opened gallon of paint sitting on the floor.
-There were two gallons of paint on the bottom shelf rack.
-There was an opened 4 pack case of 32 fluid oz of stain remover on the bottom rack shelf.

Interview with the Administrator on 02/05/20 at 5:46pm revealed:
-The door always remained unlocked.

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| D 056 | Continued From page 6<br>-The residents should not enter the pantry room because of the "Employee Only" posted sign on the pantry's door.<br><br>Second interview with the Administrator on 02/05/20 at 6:25pm revealed:<br>-She did not know that there was rule that cleaning products and other chemicals had to be locked.<br>-If a resident accidentally ingested cleaning products or hazardous chemicals then they should not be a resident at the facility. | D 056 | | |
| D 067 | 10A NCAC 13F .0305(h)(4) Physical Environment<br><br>10A NCAC 13F .0305 Physical Environment<br>(h) The requirements for outside entrances and exits are:<br>(4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure 2 of 4 exit doors, that were accessible to the residents, had sounding devices that were activated and sounded when the exit doors were opened to | D 067 | | |

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alert staff for 3 of 3 residents sampled (#1, #2, #3) who were disoriented or had diagnoses of dementia.

The findings are:

Observations at various times during the initial facility tour on 02/05/20 from 10:51am to 11:30am revealed:
-The alarm sounding device on the door at the end of the hall, by resident room #100 where Resident #2 resided, did not sound when the door was opened.
-The alarm sounding device on the door at the opposite end of the hall, closet to resident room #123, by the resident rooms of Resident #1 and #3, did not sound when the door was opened.
-The front entrance door and the back-dining room door were equipped with an alarm sounding device that sounded when the doors were opened.

Interview with a resident who lived in resident room #100 on 02/05/20 at 11:35am revealed:
-She could not recall if the alarms sounded when the two doors at the ends of the resident hall were opened.
-She only used the back door of the dining room to go in and out of the facility.
-She heard the alarm sound on the back door of the dining room when it was opened.
-She did not know if any other residents used the exit doors at the ends of the hallway.

Observation of the exit door near resident room #123 on 02/05/20 at 11:49am revealed there was no sounding alarm when the door was opened and the door was unlocked.

Interview with the resident in resident room #123

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| D 067 | Continued From page 8<br>on 02/05/20 at 11:50am revealed:<br>-The exit door located at the end of the hall by her room did not have an alarm and the exit door was unlocked during the day.<br>-She thought staff locked the exit door by her room at night, but she had never heard the door alarm when it was opened by residents or staff.<br><br>Interview with a Supervisor on 02/05/20 at 1:00pm revealed:<br>-The facility was not a locked unit and all doors did not need to be equipped with a sounding device.<br>-There were sounding door alarms on the facility's front door and the back door of the dining room because they were the main entrances to the facility.<br>-The residents could go out of the two exit doors at the end of the resident hall, but the residents did not normally use those two doors to leave the building.<br><br>Interview with the Administrator on 02/05/20 at 12:10pm revealed:<br>-All the exit doors had sounding devices on them.<br>-She did not know the door alarms were not working on the two exit doors at the end of the resident hall.<br>-Staff did not check the door alarms on the exit doors at the end of the resident halls because the residents did not usually use those two doors.<br>-No residents in the facility were disoriented or had diagnoses of dementia.<br><br>Observation of the exit doors by resident room #100 and resident room #123 on 02/06/20 from 9:25am to 9:30am revealed the sounding devices did not alarm when the two exit doors were opened at each end of the resident hall. | D 067 | | |

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Observation of the exit doors by resident room #100 and resident room #123 on 02/06/20 at 11:25am revealed the sounding devices did not alarm when the two exit doors were opened at each end of the resident hall.

1. Review of Resident #2's current FL-2 dated 06/05/19 revealed:
-Diagnoses included phobias, nerves, hypertension, cardiovascular disease, and diabetes mellitus.
-His orientation level was documented as intermittently disoriented.

Review of Resident #2's care plan dated 04/09/19 revealed Resident #2 was sometimes forgetful and needed reminders.

Review of an emergency room discharge summary form dated 12/27/19 revealed Resident #2 had a diagnosis of unspecified dementia.

Interview with a Supervisor on 02/05/20 at 1:00pm revealed:
-Resident #2 was forgetful and needed reminders sometimes.
-He did have a history of wandering and he had not exhibited exit seeking behaviors.
-Resident #2 was not disoriented or had any diagnosis of dementia.

Interview with the Administrator on 02/05/20 at 6:25pm revealed:
-Resident #2 was forgetful at times.
-He had some decline in his cognitive status but that was because of "his age"
-Resident #2 was not disoriented and did not have dementia.
-He had not exhibited any exit seeking behaviors.

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Telephone interview with a family member of Resident #2's guardian on 02/06/20 at 12:08pm revealed:
-Resident #2 was forgetful and confused sometimes.
-Resident #2 needed reminders and supervision to ensure his safety because he was occasionally confused.
-She did not know if Resident #2 had ever had any exit seeking behaviors, but "it was possible if he was confused enough."

Telephone interview with the nurse at Resident #2's primary care provider's office on 02/05/20 at 12:32pm revealed:
-Resident #2 had a diagnosis of dementia since January 2018.
-Their office had not noticed the diagnosis was not listed on Resident #2's most recent FL-2 dated 06/05/19.
-Resident #2 was intermittently disoriented, but the facility had not reported any problems with Resident #2 wandering.
-The expectation would be for all exit doors to be equipped with a sounding alarm to alert the staff to check if Resident #2 attempted to leave the facility without staff being aware.

2. Review of Resident #3's current FL-2 dated 01/09/20 revealed:
-Diagnoses included unspecified cerebral infarction, acute chronic systolic heart failure, ischemic cardiomyopathy, unspecified gout, essential primary hypertension, and chronic kidney disease - stage III.
-There was no documented assessment of the resident's orientation level.

Review of the facility's most current census report dated 02/05/20 revealed Resident #3 was

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admitted to the facility on 02/03/20.

Review of a discharge summary report from a skillled nursing facility dated 02/03/20 for Resident #3 revealed Resident #3's mental and cognitive statuses were documented as confused at times.

Observation of Resident #3 on 02/05/20 at 11:29am revealed Resident #3 was sitting on the side of his bed in room and dressed appropriately.

Interview with Resident #3 on 02/05/20 at 11:29am revealed:
-He was alert and oriented to person and place only.
-He wanted to leave the facility to go home.
-He believed a visitor in the facility was the home health nurse even after he was reoriented several times to who the visitor was.

Interview with a Supervisor on 02/05/20 at 1:00pm revealed:
-She did not know what Resident #3's orientation was because he was admitted to the facility two days ago.
-He was "very forgetful" and she had to sometimes remind Resident #3 that "he was now living at the facility and not his home".
-He had not exhibited any exit seeking behaviors since he was admitted to the facility.

Interview with the Administrator on 02/05/20 at 6:25pm revealed:
-Resident #3 was forgetful at times, but she "did not know that much about him (Resident #3) except for what was documented on Resident #3's FL-2.
-Dementia nor disorientation were documented

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on Resident #3's most current FL-2.
-She did not know Resident #3's mental and cognitive status was documented as "confused at time" in his discharge summary because she had not had a chance to review his information.
-Resident #3 had not exhibited any exit seeking behaviors since he was admitted to the facility on 02/03/20.

Telephone interview on 02/06/20 at 11:15am with a social worker from the skilled nursing facility Resident #3 was discharged from on 02/03/20 revealed:
-Resident #3 was intermittently disoriented at times and required staff to reorient him to time and place.
-She did not know if Resident #3 had exhibited any exit seeking behaviors when he was at the facility.

Interview with the Administrator on 02/06/20 at 3:10pm revealed Resident #3 had a power of attorney who made all decisions about his care because of his disorientation status.

Attempted telephone interview with Resident #3's family member on 02/06/20 at 4:49pm was unsuccessful.

3. Review of Resident #1's current FL-2 dated 11/22/19 revealed:
-Dyslipidemia, impaired fasting glucose, falls frequently, peripheral vascular disease, hypertension,
-Her orientation level was documented as intermittently disoriented.
-Her ambulation was semi-ambulatory.

Observation of Resident #1 on 02/05/20 at

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| D 067 | Continued From page 13<br>10:50am revealed she was dressed appropriately.<br><br>Interview with Resident #1 02/05/20 at 10:50am revealed she was alert and oriented to person and place only.<br><br>Interview with Resident #1 on 02/05/20 at 10:50am revealed:<br>-She preferred to use her wheelchair than her walker because she could remain sitting.<br>-She did not remember the events that happened the day before like what she ate for supper<br>-She remembered things as far back as age three.<br><br>Interview with the Administrator on 02/06/20 at 3:09pm revealed:<br>-Resident #1 was always forgetting things.<br>-Resident #1 had not been tested for dementia.<br>-Resident #1 had refused to go her last scheduled doctor's appointment. | D 067 | | |
| D 131 | 10A NCAC 13F .0406(a) Test For Tuberculosis<br><br>10A NCAC 13F .0406 Test For Tuberculosis<br>(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.<br><br>This Rule is not met as evidenced by: | D 131 | | |

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| D 131 | Continued From page 14<br><br>Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff B) was tested upon hire for Tuberculosis (TB) disease.<br><br>The findings are:<br><br>Review of Staff B's, Supervisor, personnel record revealed:<br>-Staff B was hired on 08/11/10.<br>-There was no documentation of a TB skin test upon hire.<br><br>Interview with Staff B on 02/06/20 at 3:08pm revealed:<br>-She had completed a TB skin test upon hire.<br>-She thought she had provided the TB skin test results to the Administrator.<br><br>Interview with the Administrator on 02/06/20 at 3:08pm revealed:<br>-She remembered Staff B completing a TB skin test upon hire.<br>-The results of Staff B's TB skin test had been misplaced.<br>-She could not locate Staff B's TB skin test results.<br>-She was responsible for assuring all staff completed a TB test prior to hire. | D 131 | | |
| D 139 | 10A NCAC 13F .0407(a)(7) Other Staff Qualifications<br><br>10A NCAC 13F .0407 Other Staff Qualifications<br>(a) Each staff person at an adult care home shall:<br>(7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; | D 139 | | |

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| D 139 | Continued From page 15<br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to assure 1 of 3 sampled staff, (Staff B), had a statewide criminal background check completed upon hire.<br><br>The findings are:<br><br>Review of Staff B's, Supervisor, personnel record revealed:<br>-Staff B was hired on 08/11/10.<br>-There was no documentation of a signed consent for a criminal background check for Staff B.<br>-There was documentation of a finger printing card dated 04/11/07.<br>-There was no documentation of a statewide criminal background check completed for Staff B.<br><br>Interview with Staff B on 02/06/20 at 3:08pm revealed:<br>-She had worked at the facility since 2010.<br>-Staff B had completed a criminal background check prior to her hire.<br>-She could not locate the results of the criminal background check.<br>-The Administrator was responsible for ensuring statewide criminal background checks were completed.<br><br>Interview with the Administrator on 02/06/20 at 3:09pm revealed:<br>-She thought Staff B had completed the state criminal background check.<br>-She could not locate the results of the 04/11/07 criminal background check.<br>-She was the person responsible for ensuring all employee records were up to date.<br>-She was the person responsible for the completing statewide criminal background | D 139 | | |

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| D 139 | Continued From page 16<br>checks. | D 139 | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to assure the implementation of physician's orders for 1 of 3 sampled residents (#3) for oxygen.<br><br>The findings are:<br><br>Review of Resident #3's current FL-2 dated 01/09/20 revealed:<br>-Diagnoses included unspecified cerebral infarction, acute chronic systolic heart failure, ischemic cardiomyopathy, unspecified gout, essential primary hypertension, and chronic kidney disease - stage III.<br>-There was an order for oxygen 2 liters per minute as needed. | D 276 | | |

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| D 276 | Continued From page 17<br><br>Review of the facility's most current census report on 02/05/20 revealed Resident #3 was admitted to the facility on 02/03/20.<br><br>Observation of Resident #3's room on 02/05/20 at 11:29am revealed there was no oxygen available.<br><br>Observation of Resident #3's room on 02/06/20 at 9:45am revealed there was no oxygen available.<br><br>Observation of the facility on 02/05/20 and 02/06/20 revealed there was no supplemental oxygen available for Resident #3.<br><br>Observation of Resident #3 on 02/06/20 at 9:45am revealed:<br>-He was sitting up with the head of his bed elevated at approximately a 60-degree angle.<br>-His respirations were even and unlabored.<br><br>Interview with Resident #3 on 02/06/20 at 9:45am revealed:<br>-He was not sure how long he had been at the facility.<br>-He had used oxygen as needed when he was at his previous facility for shortness of breath.<br>-He could not remember the last time he had used his oxygen.<br>-He was having some shortness of breath on 02/06/20 because there was an odor in his room that made it hard for him to breath.<br>-Oxygen would make it easier for him to breathe.<br>-He had not complained to any staff about his shortness of breath or the odor in the room.<br><br>Interview with a Supervisor on 02/05/20 at 4:35pm revealed:<br>-Resident #3 had transferred from a skilled facility two days ago. | D 276 | | |

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| D 276 | Continued From page 18 | D 276 | | |

-She did not know Resident #3 had an order for oxygen.
-The Administrator was responsible for reviewing the residents' FL-2 information and making sure the orders were implemented.
-The Administrator told the staff what the residents needed from the FL-2 and physician's orders.
-The Administrator had not told her Resident #3 had an order for oxygen as needed.

Interview with the Administrator on 02/05/20 at 6:25pm revealed:
-She was responsible for reviewing Resident #3's FL-2 information and telling the staff what orders needed to be implemented.
-She had Resident #3's FL-2 information for two weeks prior to his admission .
-She did not know Resident #3 had an order for oxygen on his FL-2.
-She must have overlooked the order for oxygen and no one from his previous facility had told her Resident #3 needed oxygen.

Telephone interview with a social worker, from the skilled nursing facility Resident #3 transferred from, on 02/06/20 at 11:15am revealed:
-The physician's order for Resident #3 to have 2 liter of oxygen was needed was correct according to their records.
-She was not sure the last time Resident #3 required the use of oxygen.
-It was the expectation for Resident #3 to have oxygen available for his use at his next facility if he needed it.
-That was the reason why the physician wrote the order for oxygen on Resident #3's FL-2.

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| D 295 | Continued From page 19 | D 295 | | |
| D 295 | 10A NCAC 13F .0904(c)(6) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition And Food Service<br>(c) Menus in Adult Care Homes:<br>(6) Menus for all therapeutic diets shall be planned or reviewed by a registered dietitian. The facility shall maintain verification of the registered dietitian's approval of the therapeutic diets which shall include an original signature by the registered dietitian and the registration number of the dietitian.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to obtain therapeutic diets menus from a registered dietitian for 1 of 3 residents sampled (Resident #1) and physician's order for a mechanical soft diet.<br>The findings are:<br><br>Review of Resident #3's current FL-2 dated 01/09/20 revealed:<br>-Diagnoses included cerebral infraction, cerebral infraction unspecified, acute chronic systolic heart failure, unspecified atrial fibrillation, ischemic cardiomyopathy, gout, unspecified, chronic kidney disease and essential (primary) hypertension.<br>-There was an order for a mechanical soft diet.<br><br>Review of a physician's order dated 02/03/20 revealed an order for a mechanical soft diet and regular/thin liquids.<br><br>Observation in the kitchen on 02/05/20 at 12:05pm revealed, there was not a therapeutic menu available. | D 295 | | |

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| D 295 | Continued From page 20<br><br>Review of the flip chart menus on 02/05/20 at 12:05pm revealed:<br>-There was not a distinction for which menu was to be used for lunch and dinner.<br>-The menus were not dated.<br>-There was a breakfast menu posted of pancake with syrup, turkey bacon, fruit, coffee, orange juice, water and butter or jelly.<br>-There was a menu posted of salisbury steak, mashed potatoes, corn, white or wheat bread, pudding or cake, tea and water.<br>-The menus on the flip chart were not signed and dated by a registered dietitian.<br><br>Observation in the kitchen on 02/06/20 at 11:08am revealed:<br>-There was a flip chart of various menus, but no date was listed on the menus.<br>-The menu posted for breakfast was the same from the previous day and did not list the serving amounts.<br>-The menu served for lunch the previous day was posted and did not list the serving amounts.<br><br>Observation of lunch on 02/05/20 at 12:10pm revealed:<br>-Resident #3 was served salisbury steak, mashed potatoes, cream corn, bread, pudding or cake, tea and water.<br>- Resident #3 chewed his food with fast bites on the right side of his mouth.<br>-Resident #3 consumed all of his meal.<br><br>Observation of the dinner on 02/05/20 at 6:04pm revealed:<br>-Resident #3 was served was hamburger on a bun, potato chips, tea and water.<br>-Resident #3 chewed his food with fast bites on the right side of his mouth. | D 295 | | |

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| D 295 | Continued From page 21<br>-Resident #3 finished his meal at 6:19pm.<br><br>Interview with Resident #3 on 02/05/20 at 4:56pm revealed:<br>-He did not know if he had a mechanical soft diet.<br>-His meat was not "chopped up" when served to him.<br>-He was able to chew and swallow his food.<br><br>Interview with a medication aide (MA) on 02/05/20 at 12:05pm:<br>-She prepared and served the meals.<br>-She "thought" the menus were approved by a registered dietitian.<br>-She followed the posted flip chart of various menus for meal preparation and serving.<br>-She used the 1991 dietary manual for measurements at times when preparing meals.<br><br>Interview with a second medication aide (MA) on 02/05/20 at 5:03pm revealed:<br>-She prepared meals according to the posted flip chart of various meals or gone on what residents had not eaten in the past few weeks.<br>-Special diets were not posted.<br>-She knew "by heart" of the residents who had therapeutic diets.<br>-She learned of residents' special diets by reviewing their record or she asked the resident.<br>-She was not familiar with Resident #3's having a mechanical soft diet.<br>-The dinner meal was the first time she had prepared and served to Resident #3.<br>-She had not asked Resident #3 if he was on a therapeutic diet.<br>-She did not know if the menus were approved by a registered dietitian.<br><br>Interview with the Supervisor on 02/05/20 at 11:52am revealed: | D 295 | | |

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| D 295 | Continued From page 22<br>-There was not a therapeutic diet signed by a registered dietitian.<br>-The staff prepared meals by using a 1991 dietary manual.<br>-The Administrator created the menus.<br>-She had not asked Resident #3 if he had a therapeutic diet.<br>-She made the staff aware of residents who had therapeutic diets.<br>-She had not informed the staff of Resident #3's therapeutic diet.<br>-Staff were trained on how to prepare special diets by the Administrator.<br><br>Interview with the Administrator on 02/06/20 at 3:09pm revealed:<br>-She had Resident #3's record two weeks prior to his admission.<br>-She did not review Resident #3's record until moments before the interview.<br>-She had not had the time to review Resident #3's record.<br>-Resident #3 had been admitted on 02/03/20.<br>-She trained the staff on how to prepare therapeutic diets.<br>-She prepared the menus.<br>-She used a 1991 dietary manual and her knowledge on how to prepare therapeutic diets.<br>-She was responsible for informing staff about residents who had therapeutic diets. | D 295 | | |
| D 299 | 10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition And Food Service<br>(d) Food Requirements in Adult Care Homes:<br>(3) Daily menus for regular diets shall include the following:<br>(A) Homogenized whole milk, low fat milk, skim | D 299 | | |

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| D 299 | Continued From page 23 | D 299 | | |

milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to assure 8 ounces of milk was served twice daily to residents.

The findings are:

Review of the facility's census on 02/05/20 revealed 11 residents resided in the facility.

Observation in the kitchen on 02/05/20 at 12:05pm revealed, there was a frozen one-gallon container of 2% milk sitting in the kitchen sink.

Observation of the refrigerator in the pantry off the kitchen on 02/05/20 at 12:05pm revealed:
-There was no milk stored in any of the three kitchen refrigerators.
-There were breakfast and lunch menus posted that did not list milk to be served.

Observation of the lunch meal on 02/05/20 at 12:10pm revealed:
-There were 11 residents who were served their meal.
-The residents were served a choice of tea or lemonade and water.
-There was no milk served or offered to the residents to drink with their meal.

Observation of the refrigerator and freezer in the second pantry on 02/05/20 at 5:16pm revealed:

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| D 299 | Continued From page 24<br>-There were three frozen gallons of 2% milk in the freezer.<br>-There was no milk in the refrigerator.<br><br>Observation of the dinner meal on 02/05/20 at 6:04pm revealed:<br>-There were 11 residents served who were their meal.<br>-The residents were served a choice of tea and water.<br>-There was no milk served or offered to the residents.<br><br>Interview with a resident on 02/05/20 at 10:50am revealed:<br>-She did not always have milk with her meals.<br>-Milk was sometimes served at breakfast.<br>-Milk was not served at any other meal.<br>-The resident did not know if milk was available to drink at lunch or dinner.<br><br>Interview with a second resident on 02/05/20 at 10:59am revealed:<br>-Milk was not served for breakfast.<br>-Residents had to ask for milk.<br>-The resident had never requested milk.<br><br>Interview with a third resident on 02/05/20 at 11:17am revealed:<br>-Milk was served "sometimes", but not every day.<br>-The resident stated, "When they serve you milk, it is for breakfast."<br>-The resident had not requested to be served milk.<br><br>Interview with a medication aide (MA) on 02/05/20 at 12:02pm revealed:<br>-She had placed the frozen gallon of milk in the kitchen sink to thaw.<br>-She had not served milk for breakfast that day | D 299 | | |

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| D 299 | Continued From page 25<br>because pancakes were served and not cereal.<br>-She did not know milk was to be served twice a day.<br>-She followed the posted menu to prepare breakfast.<br>-She had not realized the posted menu did not list milk to be served.<br>-She knew to serve milk with cereal.<br><br>Interview with the Supervisor on 02/05/20 at 11:53am revealed:<br>-The MAs and personal care aides (PCAs) prepared and served meals.<br>-Residents were served milk at breakfast if the menu "called for it".<br>-Residents did not request milk.<br>-She had not realized the posted menu did not list milk to be served.<br>-The breakfast menu was not created by a licensed dietitian.<br><br>Interview with the Administrator on 02/05/20 at 3:09pm revealed:<br>-She did not use a licensed dietitian to prepare the menus.<br>-She prepared the menus.<br>-The posted menus were used daily and interchangeably when needed.<br>-She did not know the posted menus did not list milk to be served.<br>-Residents were offered their "drink of choice" daily.<br>-Milk was available upon a resident's request.<br>-She did not know milk was to be served twice daily. | D 299 | | |
| D 309 | 10A NCAC 13F .0904(e)(3) Nutrition and Food Service | D 309 | | |

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| D 309 | Continued From page 26<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interviews the facility failed to maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff for 1 of 3 (Resident #3) sampled residents with physician's orders for a mechanical soft diet and nutrtional supplements..<br><br>The findings are:<br><br>1. Review of Resident #3's current FL-2 dated 01/09/20 revealed diagnoses included cerebral infarction, acute chronic systolic heart failure, unspecified atrial fibrillation, ischemic cardiomyopathy, gout, unspecified, chronic kidney disease and essential (primary) hypertension.<br>-There was an order for a mechanical soft diet.<br><br>a. Review of a physician's order dated 02/03/20 revealed, there was an order for a mechanical soft diet.<br><br>Observation in the kitchen on 02/05/20 at 12:05pm revealed, there was not a list of physician-ordered therapeutic diets posted.<br><br>Review of a discharge summary report from a skill nursing facility dated 02/03/20 for Resident #3 revealed: | D 309 | | |

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| D 309 | Continued From page 27<br>-Resident #3 had a diagnosis of dysphagia.<br>-There was an order for a mechanical soft diet.<br><br>Interview with the medication aide (MA) on 02/05/20 at 5:03pm revealed:<br>-She knew "by heart" of the residents who had therapeutic diets.<br>-She learned of residents' special diets by reviewing their record or she asked the resident.<br>-There was not a list of residents who required therapeutic diets and she did not know if any residents were currently on a mechanical soft diet.<br><br>Interview with the Supervisor in Charge (SIC) on 02/05/20 at 6:02pm revealed:<br>-She knew which residents who were on a therapeutic diet.<br>-She did not know if Resident #3 was suppose to be on a mechanical soft diet since he was only admitted to the facility on 02/03/20.<br>-There was not a list of residents who required therapeutic diets.<br>-The Administrator was responsible for keeping up with the residents' diet orders.<br><br>Interview with the Administrator on 02/06/20 at 3:09pm revealed:<br>-She did not know to post the therapeutic menu.<br>-She was responsible for informing staff about residents who had therapeutic diets.<br>-She did not know Resident #3 had an order for a mechanical soft diet.<br>-She missed the order on the FL-2 and the subsequent order written on 02/03/20.<br><br>b.Review of Resident #3's physician's order dated 02/03/20 revealed there was an order for a nutritional supplement - 8 ounces twice a day for poor appetite to be taken with medications. | D 309 | | |

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| D 309 | Continued From page 28<br><br>Interview with the medication aide (MA) on 02/05/20 at 5:03pm revealed she did not know Resident #3 was supposed to receive nutritional supplements.<br><br>Interview with the Supervisor in Charge (SIC) on 02/05/20 at 6:02pm revealed:<br>-She knew which residents who were on a therapeutic diet.<br>-She did not know if Resident #3 was suppose have a nutritional supplement since he was only admitted to the facility on 02/03/20.<br>-There was not a list of residents who required nutritional supplements.<br>-The Administrator was responsible for keeping up with the residents' diet orders.<br><br>Interview with the Administrator on 02/06/20 at 3:09pm revealed:<br>-She did not know Resident #3 had an order for nutritional supplement when he was admitted to the facility.<br>-Resident #3 had not been given the nutritional supplement and there was not any on site to serve to Resident #3.<br>-She was responsible for informing staff about the residents' dietary orders. | D 309 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. | D 310 | | |

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| D 310 | Continued From page 29 | D 310 | | |

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to assure therapeutic diets were served as ordered for 1 of 3 sampled residents (#3) with orders for a mechanical soft diet and serving a nutritional supplement two times day for poor appetite with medications.

The findings are:

Review of Resident #3's current FL-2 dated 01/09/20 revealed:
-Diagnoses included cerebral infraction, cerebral infraction unspecified, acute chronic systolic heart failure, unspecified atrial fibrillation, ischemic cardiomyopathy, gout, unspecified, chronic kidney disease and essential (primary) hypertension.
-There was an order for a mechanical soft diet.

Review of the facility's most current census report on 02/05/20 revealed Resident #3 was admitted to the facility on 02/03/20.

a. Review of a discharge summary report from a nursing skilled facility dated 02/03/20 for Resident #3 revealed:
-Resident #3 had a diagnosis of dysphagia.
-There was an order for a mechanical soft diet.

Observation of the flip chart menus posted on the wall in the kitchen on 02/05/20 at 12:05pm revealed:
-The menus were not dated.
-There was a breakfast menu for pancake with syrup, turkey bacon, fruit, coffee, orange juice, water and butter or jelly.
-There was a lunch menu for salisbury steak, mashed potatoes, corn, white or wheat bread, pudding or cake, tea and water.
-There was no menu for a mechanical soft diet.

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| D 310 | Continued From page 30<br><br>Observation of lunch on 02/05/20 at 12:10pm revealed:<br>-Resident #3 was served salisbury steak, mashed potatoes, cream corn, bread, pudding or cake, tea and water.<br>- Resident #3 chewed his food with fast small bites on the right side of his mouth.<br>-Resident #3 consumed all of his meal.<br><br>Observation of the dinner on 02/05/20 at 6:04pm revealed:<br>-Resident #3 was served was hamburger on a bun, potato chips, tea and water.<br>-Resident #3 chewed his food with fast bites on the right side of his mouth.<br>-Resident #3 finished his meal at 6:19pm.<br><br>Observation in the kitchen on 02/06/20 at 11:08am revealed:<br>-There was a flip chart of various menus, but no date was listed on the menus.<br>-There was no menu for a mechanical soft diet.<br><br>Interview with Resident #3 on 02/05/20 at 4:56pm revealed:<br>-He did not know if he had been served a mechanical soft diet.<br>-His meat was not "chopped up" when served to him.<br>-He was able to chew and swallow his food.<br><br>Second interview with Resident #3 on 02/06/20 at 9:45am revealed:<br>-He was not sure how long he had been at the facility.<br>-He did not know if he was supposed to have a special diet.<br>-He denied any problems with chewing or swallowing his food. | D 310 | | |

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| D 310 | Continued From page 31 | D 310 | | |

-He ate a hamburger and potato chips the staff gave him for supper on 02/05/20 because he was hungry.
-He could not remember if staff had offered him something else to eat for the supper on 02/05/20.

Interview with a medication aide (MA) on 02/05/20 at 5:03pm revealed:
-She prepared the meals.
-Therapeutic diets were not posted.
-She knew "by heart" of the residents who had therapeutic diets.
-She learned of residents' therapeutic diets by reviewing their record or she asked the resident.
-She did not know Resident #3 had an order for a mechanical soft diet.
-The dinner on 02/03/20 was the first time she had prepared and served to Resident #3 and she did not serve him a mechanical soft diet and did not specify what she served for the meal.
-She had not asked Resident #3 if he was on a therapeutic diet.
-She knew how to prepare mechanical soft diets.
-The MA was not informed by the Supervisor in Charge (SIC) of Resident #3's therapeutic diet.

Interview with the Supervisor on 02/05/20 at 6:02pm revealed:
-She did not review Resident #3's FL-2 or his record prior to his admission to the facility.
-She had not asked Resident #3 if he had a therapeutic diet.
-She made the staff aware of residents who had therapeutic diets.
-She had not informed the staff of Resident #3's therapeutic diets.
-Staff were trained on how to prepare special diets by the Administrator.

Interview with the Administrator on 02/06/20 at

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| D 310 | Continued From page 32 | D 310 | | |

3:09pm revealed:
-She had Resident #3's record two weeks prior to his admission.
-She had not reviewed Resident #3's record.
-She had not had the time to review Resident #3's record.
-She did not know Resident #3 had an order for a mechanical soft diet.
-She trained the staff on how to prepare therapeutic diets.
-She used a 1991 dietary manual and her knowledge on how to prepare therapeutic diets.
-She was responsible for informing staff about residents who had therapeutic diets.

b. Review of a discharge summary report from a nursing skilled facility dated 02/03/20 for Resident #3 revealed:
-Resident #3 had a diagnosis of dysphagia.
-There was an order for nutritional supplement 8 ounces twice daily for poor appetite..

Observation in the pantry off of the kitchen on 02/05/20 at 12:05pm revealed there was not any nutritional supplements available in the kitchen or pantry for Resident #3.

Interview with Resident #3 on 02/05/20 at 4:56pm revealed:
-He had not been given the nutritional supplement since his admission.
-He liked to take his nutritional supplement with his medication because it helped with swallowing the medications.
-Staff had not mentioned his need to take the nutritional supplement.
-He had not asked for the nutritional supplement since he came to the facility.
-He did not know how to ask staff for the nutritional supplement because he did not know

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| D 310 | Continued From page 33<br>which staff to ask.<br><br>Interview with a medication aide (MA) on 02/05/20 at 5:03pm revealed:<br>-She did not know with Resident #3's order for nutritional supplement.<br>-She had not administered the nutritional supplement to Resident #3.<br>-There were no nutritional supplement available for Resident #3.<br>-The MA was not informed by the Supervisor in Charge (SIC) of Resident #3's nutritional supplement.<br><br>Interview with the Supervisor on 02/05/20 at 6:02pm revealed:<br>-She did not review Resident #3's FL-2 or his record prior to his admission to the facility.<br>-She did not know Resident #3 had a physician's order to take nutritional supplement.<br>-There was not any nutritional supplement on the premises for Resident #3.<br><br>Interview with the Administrator on 02/06/20 at 3:09pm revealed:<br>-She had Resident #3's record two weeks prior to his admission.<br>-She had not reviewed Resident #3's record.<br>-She had not had the time to review Resident #3's record.<br>-She did not know Resident #3 had an order for nutritional supplement. | D 310 | | |
| D 451 | 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents<br><br>10A NCAC 13F .1212 Reporting of Accidents and Incidents<br>(a) An adult care home shall notify the county | D 451 | | |

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| D 451 | Continued From page 34<br>department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to notify the county department of social services of incidents resulting in injury requiring medical treatment and referral to local hospital for emergency medical evaluation for 1 of 3 residents sampled (#2).<br><br>The findings are:<br><br>Review of Resident #2's current FL-2 dated 06/05/19 revealed diagnoses included phobias, nerves, hypertension, cardiovascular disease, and diabetes mellitus.<br><br>Review of an emergency room discharge summary dated 12/27/19 for Resident #2 revealed Resident #2's treatment diagnoses included initial encounter for a fall and unspecified dementia.<br><br>Interview with Resident #2 on 02/05/20 at 3:43pm revealed he did not remember falling or going to the hospital on 12/27/19.<br><br>Telephone interview with a family member of Resident #2's guardian on 02/06/20 at 12:08pm revealed: | D 451 | | |

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| D 451 | Continued From page 35<br>-She received a call on 12/27/19 from staff at the facility that Resident #2 had fallen and had been sent to the emergency room.<br>-She could not remember who called her from the facility on 12/27/19.<br><br>Interview with a Supervisor on 02/06/20 at 10:15am revealed:<br>-The facility did not document when residents had falls or injuries.<br>-The facility did not have incident/injury reports.<br>-She could not recall if Resident #2 had fallen in December 2019.<br><br>Attempted telephone interview with the Adult Home Specialist with the county Department of Social Services (DSS) on 02/06/20 at 10:55am was unsuccessful.<br><br>Interview with the Administrator on 02/06/20 at 3:10pm revealed:<br>-The facility did not document when residents fell at the facility.<br>-The facility did not have any incident reports and she did not notify DSS when residents sustained any type of injuries that required anything beyond basic first aid.<br>-She "had instructed staff to document residents' falls and injuries by exception only", but Resident #2's "fall on 12/27/19 was not documented because he was not hurt".<br>-She could not explain what documening "falls and injuries by exception only" meant.<br>-Resident #2 was sent to the emergency room to make sure he was "okay" after he fell. | D 451 | | |
| D934 | G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements | D934 | | |

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| D934 | Continued From page 36<br>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements<br><br>(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<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to assure 2 of 3 staff sampled (Staff A and Staff B) who were employed as medication aides had completed the state approved annual infection control training.<br><br>The findings are:<br><br>1. Review of the personnel record for Staff A, medication aide (MA)/housekeeper on 02/06/20 revealed:<br>-Staff A's date of hire was documented as 08/21/13. | D934 | | |

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| D934 | Continued From page 37<br>-Staff A successfully passed the state written medication administration exam on 04/16/14.<br>-There was documentation of a completed Medication Administration Clinical Skills Validation Checklist dated 02/20/14 for Staff A.<br>-There was documentation Staff A's last state approved infection control training was completed on 10/16/18.<br>-There was no documentation of completion of the state approved infection control training since 10/16/18 in Staff A's personnel record.<br><br>Attempted telephone interview with Staff A on 02/06/20 at 4:54pm was unsuccessful.<br><br>Refer to interview with the Administrator on 02/06/20 at 3:10pm.<br><br>2. Review of the personnel record for Staff B, medication aide (MA)/supervisor on 02/06/20 revealed:<br>-Staff B's date of hire was documented as 08/11/10.<br>-Staff B successfully passed the state written medication administration exam on 08/11/10.<br>-There was documentation of a completed Medication Administration Clinical Skills Validation Checklist dated 08/02/10.<br>-There was documentation Staff B's last state approved infection control training was completed on 10/16/18.<br>-There was no documentation of completion of the state approved infection control training since 10/16/18 in Staff B's personnel record.<br><br>Interview with Staff B on 02/06/20 at 2:45pm revealed:<br>-She believed she had completed her annual infection control training sometime in the fall of 2019. | D934 | | |

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| NEEDHAM ADULT CARE HOME | 916A S SANDY HOOK ROAD SHILOH, NC 27974 |

| (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 |
|---|---|---|---|---|
| D934 | Continued From page 38<br>-A copy of her completed infection control training should have been in her personnel record.<br>-The Administrator was responsible for providing the medication aide's infection control training.<br><br>Refer to interview with the Administrator on 02/06/20 at 3:10pm.<br><br>_____<br>Refer to interview with the Administrator on 02/06/20 at 3:10pm revealed:<br>-She was a registered nurse.<br>-She was responsible for providing the annual infection control training for the medication aides at the facility.<br>-She thought she did the infection control training for Staff A and Staff B in October 2019 or November 2019 and copies of the completed training should have been placed in their personnel records.<br>-The annual infection control training had been done but she had probably misfiled the documentation. | D934 | | |
| D935 | G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency<br><br>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.<br><br>(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:<br>(1) A five-hour training program developed by the Department that includes training and instruction | D935 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL015002 | A. BUILDING: _____ B. WING _____ | 02/06/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| D935 | Continued From page 39<br>in all of the following:<br>a. The key principles of medication administration.<br>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.<br>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.<br>(3) Within 60 days from the date of hire, the individual must have completed the following:<br>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:<br>1. The key principles of medication administration.<br>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.<br>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure 1 of 2 sampled medication aides (Staff A) had completed their 5, 10, or 15 hour state approved | D935 | | |

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|---|---|---|---|---|
| D935 | Continued From page 40<br>medication training.<br><br>The findings are:<br><br>Review of the personnel record for Staff A, medication aide (MA)/housekeeper on 02/06/20 revealed:<br>-Staff A's date of hire was documented as 08/21/13.<br>-Staff A successfully passed the state written medication administration exam on 04/16/14.<br>-There was documentation of a completed Medication Administration Clinical Skills Validation Checklist dated 02/20/14.<br>-There was no documentation of completion of the 15-Hour State-approved Medication Administration Training for Adult Care Homes for Staff A.<br><br>Review of the facility's December 2019 electronic Medication Administration Record (eMAR) revealed:<br>-Staff A documented administering medications at 8:00am on 12/02/19, 12/07/19, 12/08/19, 12/16/19, 12/17/19, 12/20/19, 12/21/19, 12/22/19, 12/23/19, and 12/24/19.<br>-Staff A documented administering medications at 4:00pm on 12/02/19, 12/07/19, 12/08/19, 12/16/19, 12/20/19, 12/21/19, 12/22/19, and 12/23/19.<br>-Staff A documented administering medications at 6:00pm and 8:00pm on 12/07/19, 12/08/19, 12/16/19, 12/20/19, 12/22/19, and 12/23/19.<br><br>Review of the facility's January 2020 eMAR revealed:<br>-Staff A documented administering medications at 8:00am on 01/03/20, 01/04/20, 01/17/20, 01/18/20, and 01/19/20.<br>-Staff A documented administering medications at | D935 | | |

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| D935 | Continued From page 41<br>4:00pm on 01/03/20, 01/04/20, 01/05/20, 01/15/20, 01/17/20, 01/18/20, and 01/19/20.<br>-Staff A documented administering medications at 6:00pm and 8:00pm on 01/04/20, 01/17/20, and 01/18/20.<br><br>Review of the facility's February 2020 eMAR revealed:<br>-Staff A documented administering medications at 8:00am and 4:00pm on 02/02/20 and 02/03/20.<br>-Staff A documented administering medications at 6:00pm and 8:00pm on 02/01/20.<br><br>Attempted telephone interview with Staff A on 02/06/20 at 4:54pm was unsuccessful.<br><br>Interview with the Administrator on 02/06/20 at 3:10pm revealed:<br>-She was a registered nurse.<br>-She was responsible for the medication aide training for staff at the facility.<br>-She thought Staff A had completed of the 15 hour medication administration training when she completed Staff A's medication administration clinical skills checklist.<br>-She thought she had put a copy of Staff A's completed 15 hour medication administration training in Staff A's personnel file. | D935 | | |