STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal002004	A. BUILDING: _____ B. WING _____	R 02/02/2015

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ALEXANDER ASSISTED LIVING	3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 and the Alexander County Department of Social Services conducted an annual, follow-up and complaint investigation on January 27, 28 & 29, 2015 with an exit conference via telephone on February 02, 2015. The complaint investigation was initiated by the Alexander County Department of Social Services on December 09, 2014.	D 000		
D 176	10A NCAC 13F .0601 Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Facility Services and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record review, the Administrator failed to assure the total operation of the facility met and maintained rules related to management of the facility, nutrition and food service, medication administration, controlled substances, infection prevention,	D 176		

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D 176	Continued From page 1	D 176		

infection prevention training, medication aide training and resident rights.

The findings are:

Interview with the Director on 01/29/15 at 3:00pm revealed:
- The Administrator was present in the facility about twice a week.
- The Administrator was not involved with resident care.
- The Administrator routinely delegated management tasks and responsibilities to the Director.

Interview with the facility Administrator on 01/28/15 at 3:52pm revealed he believed staff were using disposable lancet devices to obtain FSBS.

Interview with the facility Director and Administrator on 01/29/15 at 11:15am revealed neither of them were sure if staff had completed the staff approved infection control training.

Areas of non-compliance identified during the survey were:

A. Based on observations, record review and interviews, the facility failed to store and prepare food in a manner to protect from contamination. [Refer to Tag 283 10A NCAC 13F .0904(a)(2). (Type B Violation).]

B. Based on observations and interviews the facility failed to provide table services that included a knife for all residents. [Refer to Tag 287 10A NCAC 13F .0904(b)(2).]

C. Based on observations and interviews the

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D 176	Continued From page 2 facility failed to maintain matching therapeutic diet menus in the kitchen for therapeutic diets as ordered by the physician for guidance of food service staff for 9 of 9 residents with therapeutic diets. (Residents #2, 3, 4, 5, 7, 8, 10, 11 & 12.) [Refer to Tag 296 10A NCAC 13F .0904(c)(7).] D. Based on observations and interviews the facility failed to serve water to each resident in addition to other beverages. [Refer to Tag 306 10A NCAC 13F .0904(d)(3)(H).] E. Based on observations and interviews the facility failed to maintain a current listing of residents with therapeutic diets ordered by the physician for guidance of food service staff for 9 of 9 residents with therapeutic diets. (Residents #2, 3, 4, 5, 7, 8, 10, 11 & 12.) [Refer to Tag 309 10A NCAC 13F .0904(e)(3).] F. Based on observations, record reviews, and interviews, the facilty failed to assure residents received medications as ordered by a licensed prescribing practitioner for 5 of 8 residents. (Residents #4, #5, #6 , #2 and #3.) (Lopressor, Digoxin, Novolog, Lorazepam, and Metformin.) [Refer to Tag 358 10A NCAC 13F .1004(a) (Type B Violation).] G. Based on observations, record reviews and interviews, the facility failed to properly store Schedule II medication under double lock and proper supervision at all times. [Refer to Tag 393 10A NCAC 13F .1008(b) (Type B Violation).] H. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing a lancing device when used for different	D 176		

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D 176	Continued From page 3 residents for 8 of 8 sampled residents with orders for finger stick blood sugars (FSBS). (Residents #3, #4, #7, #8, #9, #10, #11, and #12.) [Refer to Tag D932 G.S. 131D-4.4A(b) (Type A2 Violation).] I. Based on record reviews and interviews, the facility failed to assure 1 of 1 Medication Aide staff, employed at the facility for at least one year, had completed the annual state approved infection control training. (Staff A). [Refer to Tag D934 G.S. 131D-4.5B(a) (Type B Violation).] J. Based on observations, record reviews and interviews, the facility failed to assure 2 of 3 sampled Medication Aide staff who were hired, or began performing Medication Aides duties after 10/01/13 met the requirements for performing unsupervised Medication Aide duties. (Staff B and Staff D.) [Refer to Tag D935 G.S. 131D-4.5B(b) (Type B Violation).] _____ A Plan of Protection was submitted by the facility on 01/29/15 that included: -The Administrator will oversee and routinely monitor the day to day operations of the facility to ensure the rules are being met starting today, January 29, 2015. - The Administrator will randomly monitor areas of deficient practice and follow-up with the Director to ensure all regulations are being followed. DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 04, 2015.	D 176		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service	D 283		

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D 283	Continued From page 4 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record review and interviews, the facility failed to store and prepare food in a manner to protect from contamination. The findings are: Initial observations of the kitchen and food storage areas on January 27, 2015 beginning at 10:00am revealed: - Heating and air intake vent in the kitchen was covered with a heavy build-up of dust and debris. - Ice maker vent was covered with a thick buildup of dust and debris. - The vent above the cook stove was covered with a thick build-up of dust and grease. - Back side of the stove was covered with a thick build-up of dust and debris. - Microwave interior was covered with a thick build-up of splattered food; microwave exterior smeared with smudges and debris. - The refrigerator and freezer handles were covered with smudges and a sticky substance. - Refrigerator in main kitchen area had several dark pink round meat slices stored in a plastic bag, not labeled or dated; a shredded cheese stored in a plastic bag open to air; and a large frying pan covered with plastic wrap that contained a thick white congealed substance, not labeled. - The bottom shelves of the refrigerator and	D 283		

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freezer were covered with a large amount of crumbs and food debris.
- The freezer in the storage room had a large plastic bag of breaded fish fillets open to air.
- The lids on the sugar and flour containers covered with stains, smears and smudges.
- A large plastic trash can in the storage room labeled as "shortening" had an thick white substance with a foul rancid odor inside a plastic liner, open to air.
- The shelves in the storage room had several bags of animal crackers and vanilla wafers open to air.
- No test strips were available for use with the automatic dish machine sanitizer.

Interview with Cook A on January 27, 2015 at 10:30am revealed:
- Cook A had worked at the facility "about 2 months" and did not recall ever taking the Food Service Orientation training or the test.
- Cook A stated there was no cleaning schedule for the kitchen.
- Cook A stated she had never used the "shortening" located in storage room and did not "even know" what was in that container.

Review of Cook A's personnel file revealed a hire date of December 17, 2014 and a certificate of the Food Services Orientation with post test dated December 18, 2014.

Observations in the kitchen on January 28, 2015 at 9:30am revealed:
- (2) packages of thinly sliced sandwich ham floating in warm water in the sink.
- The water temperature was 104 degrees Fahrenheit.
- The ham was warm and soft to touch.

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Interview with Cook B on January 28, 2015 at 9:30am revealed:
- Cook B stated they usually thawed frozen meat in a pan of warm water in the sink.
- Cook B stated the frozen ham packages had been in the sink of warm water about "one hour".
- Cook B stated she washed all dishes in the three compartment sink before placing them in the sanitizing machine.
- Cook B stated the dishwasher machine used chemicals for sanitation (pointed to the containers of chemicals on the floor connected to the dishwasher machine).
- Cook B stated she had never had any test strips to check the amount of sanitizer in the machine.
- Cook B had worked as a cook since November 2014 and did not recall ever taking the Food Service Orientation training or the test.
- Cook B stated she would not use the meat that was thawing in the sink for lunch.

Review of Cook B's personnel file revealed a hire date of November 12, 2014 and a certificate of the Food Services Orientation and post test dated November 12, 2014.

An interview with the Director on January 27, 2015 at 3:00pm revealed there "used to be" a cleaning schedule posted in the kitchen but did not know what happened to it.

Follow up interview with the Director on January 28, 2015 at 9:45am revealed:
- Thawing frozen meat in a sink of warm water was not the proper way to thaw meat and the Director was not aware staff were doing this.
- The Director stated there had been no episodes/outbreaks of gastrointestinal illnesses.

Review of the Local Environmental Health

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D 283	Continued From page 7 Section Food Establishment Inspection Report dated 12/11/14 revealed a score of 88.0 with demerits in the following areas: - Food condition not safe. - Dirty microwave. - Leftovers not dated and labeled. - Dirty kitchen equipment surfaces. - No sanitizing test strips available for automatic dish sanitizer machine. - Inside of coolers and freezer dirty. - Kitchen storage area dirty. A Plan of Protection was submitted by the facility on January 28, 2015 that included: - The meat thawing in the sink was disposed of immediately. - All kitchen staff would be trained on the Food Service Orientation manual again to ensure knowledge of correct methods for thawing frozen meats. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 19, 2015.	D 283		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.	D 287		

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D 287	Continued From page 8 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide table services that included a knife for all residents. The findings are: Observation of the lunch meal on January 27, 2015 at 12:10pm revealed: - Residents were served thinly sliced turkey breast, broccoli/cauliflower mix, baked beans and pineapple tidbits and tea. - Residents had a place setting which included a napkin, fork and spoon. Residents were observed cutting the turkey breast using their forks with minimal effort. Random interviews with residents during the lunch observation revealed: - "We never have had a knife." - "You should see us when we have pork chops." - "I can pick it up [the meat] and bite it, I have teeth." - "It would be nice to have a knife." Interview with Cook A at this time revealed: - There were no knives available for resident use. - Cook A was not aware that table service for each resident should include a knife. Interview with the Director on January 27, 2015 at 3:00pm revealed: -The Director was not aware about the rule to provide knives for all residents. - The Director did not know whether or not the facility had knives available for resident use. Observations of the lunch meal on January 28,	D 287		

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D 287	Continued From page 9 2015 at 12:15pm revealed each resident had a knife at their place setting. A resident approached the surveyor after the meal and said: "Thank you for the knife."	D 287		
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. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain matching therapeutic diet menus in the kitchen for guidance of food service staff for therapeutic diets (diabetic and low sodium) as ordered by the physician for 9 of 9 residents with therapeutic diets. (Residents #2, 3, 4, 5, 7, 8, 10, 11 & 12.) The findings are: Observations in the kitchen on 01/27/15 at 10:00am revealed: - No therapeutic diets posted. - A regular menu for Fall/Winter Week 4 was available for staff guidance in a notebook on the counter. (This was the only menu available for guidance). Interview with Cook A on 01/27/15 at 10:30am revealed: - Cook A had worked at the facility "about 2 months" and did not recall ever taking the Food	D 296		

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Service Orientation training or the test.
- She did not know anything about a therapeutic diet menu.
- She used the regular menu in the notebook on the counter for all residents.
- She thought all residents were on a regular diet.
- Diabetics were served the same food as everyone with the exception of diet or sugar free drinks.

Review of Cook A's personnel file revealed a hire date of December 17, 2014 and a certificate of the Food Services Orientation with post test dated December 18, 2014.

Observation of the lunch meal on January 27, 2015 at 12:10pm revealed all residents were served thinly sliced turkey breast, broccoli/cauliflower mix, baked beans, pineapple tidbits and tea/coffee.

A. Review of Resident #2's record revealed:
- An FL2 dated 12/16/14 with diagnoses that included diabetes type II.
- A current diet order dated 01/09/15 for low sodium, diabetic diet.
- No FSBS (Finger Stick Blood Samples) were ordered for Resident #2.

Interview with Resident #2 on 01/28/15 revealed he did not drink beverages with sugar, otherwise ate a regular diet.

B. Review of Resident #3's record revealed:
- An FL2 dated 07/14/14 with diagnoses that included diabetes.
- A current diet order dated 10/13/14 for no concentrated sweets (NCS).
- FSBS range of 80-285 for the month of January 2015.

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D 296	Continued From page 11 Interview with Resident #3 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet. C. Review of Resident #4's record revealed: - An FL2 dated 09/30/14 with diagnoses that included diabetes. - A current diet order dated 09/30/14 for NCS. - FSBS range of 59-548 for the month of January 2015. Interview with Resident #4 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet. D. Review of Resident #5's record revealed: - An FL2 dated 09/19/14 with diagnoses that included diabetes. - A current diet order dated 09/19/14 for NCS. - No FSBS were available for review. Interview with Resident #5 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet. E. Review of Resident #7's record revealed: - An FL2 dated 09/30/14 with diagnoses that included diabetes type II. - A current diet order dated 09/30/14 for NCS. - FSBS range of 98-184 for the month of January 2015. Interview with Resident #7 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet. F. Review of Resident #8's record revealed: - An FL2 dated 01/06/15 with diagnoses that included diabetes type II.	D 296		

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D 296	Continued From page 12 - A current diet order dated 11/18/14 for NCS. - No FSBS available for Resident #8. Interview with Resident #8 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet. G. Review of Resident #10's record revealed: - An FL2 dated 09/18/14 with diagnoses that included diabetes type II. - A current diet order dated 09/18/14 NCS. - FSBS range of 84-298 for the month of January 2015. Interview with Resident #10 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet. H. Review of Resident #11's record revealed: - An FL2 dated 09/30/14 with diagnoses that included morbid obesity. - A physician progress note dated 11/18/14 with diagnosis of diabetes type II. - A current diet order dated 09/30/14 NCS. - FSBS range of 127-187 for the month of January 2015. Resident #11 was not available for interview during the survey. I. Review of Resident #12's record revealed: - An FL2 dated 09/30/14 with diagnoses that included diabetes type II. - A current diet order dated 09/30/14 NCS. - FSBS range of 97-150 for the month of January 2015. Interview with Resident #12 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet.	D 296		

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D 296	Continued From page 13 Interview with the Director on 01/28/15 at 10:00am revealed: - Therapeutic diets should be and used to be posted in the kitchen. - A lot of residents were on a diabetic diet. - The Director stated she had the therapeutic diet menus in her office. Observations revealed the therapeutic diet menus were placed in the kitchen by the exit date.	D 296		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to serve water to each resident in addition to other beverages. The findings are: Observation of the lunch meal on January 27, 2015 at 12:10pm revealed: - Residents were served tea and/or coffee for beverages. - No water was served to the residents. Random interviews with residents during the lunch observation revealed: - Water was "never" served with meals.	D 306		

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ALEXANDER ASSISTED LIVING	3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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D 306	Continued From page 14 - "We probably could ask for water and get it." - Residents would "like to have water" with meals. Interview with Cook A at this time revealed she did not know water should be served in addition to other beverages with the meals. Interview with the Director on 01/28/15 at 10:00am revealed she did not know water should be served with meals in addition to other beverages.	D 306		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to maintain an current listing of residents with therapeutic diets for guidance of food service staff for 9 of 9 residents with therapeutic diets. (Residents #2, 3, 4, 5, 7, 8, 10, 11 & 12.) The findings are: Observations in the kitchen on January 27, 2015 at 10:00am revealed: - No therapeutic diets were posted. Interview with Cook A on January 27, 2015 at 10:30am revealed: - She had never seen a therapeutic diet list posted.	D 309		

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D 309	Continued From page 15 - She thought all residents were on a regular diet. - Diabetics were served the same food as everyone with the exception of diet or sugar free drinks. A. Review of Resident #2's record revealed: - An FL2 dated 12/16/14 with diagnoses that included diabetes type II. - A current diet order dated 01/09/15 for low sodium, diabetic diet. Interview with Resident #2 revealed he did not drink beverages with sugar, otherwise ate a regular diet. B. Review of Resident #3's record revealed: - An FL2 dated 07/14/14 with diagnoses that included diabetes. - A current diet order dated 10/13/14 for no concentrated sweets (NCS). Interview with Resident #3 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet. C. Review of Resident #4's record revealed: - An FL2 dated 09/30/14 with diagnoses that included diabetes. - A current diet order dated 09/30/14 for NCS. Interview with Resident #4 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet. D. Review of Resident #5's record revealed: - An FL2 dated 09/19/14 with diagnoses that included diabetes. - A current diet order dated 09/19/14 for NCS. Interview with Resident #5 on 01/28/15, revealed	D 309		

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the resident did not know if they were on a therapeutic diet.

E. Review of Resident #7's record revealed:
- An FL2 dated 09/30/14 with diagnoses that included diabetes type II.
- A current diet order dated 09/30/14 for NCS.

Interview with Resident #7 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet.

F. Review of Resident #8's record revealed:
- An FL2 dated 01/06/15 with diagnoses that included diabetes type II.
- A current diet order dated 11/18/14 for NCS.

Interview with Resident #8 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet.

G. Review of Resident #10's record revealed:
- An FL2 dated 09/18/14 with diagnoses that included diabetes type II.
- A current diet order dated 09/18/14 NCS.

Interview with Resident #10 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet.

H. Review of Resident #11's record revealed:
- An FL2 dated 09/30/14 with diagnoses that included morbid obesity.
- A physician progress note dated 11/18/14 with diagnosis of diabetes type II.
- A current diet order dated 09/30/14 NCS.
- FSBS range of 127-187 for the month of January 2015.

Resident #11 was not available for interview any

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D 309	Continued From page 17 days of the survey. I. Review of Resident #12's record revealed: - An FL2 dated 09/30/14 with diagnoses that included diabetes type II. - A current diet order dated 09/30/14 NCS. Interview with Resident #12 on 01/28/15, revealed the resident did not know if they were on a therapeutic diet. Interview with the Director on 01/28/15 at 10:00am revealed: - Therapeutic diets should be and used to be posted in the kitchen. - A lot of residents were on a diabetic diet. - The Director did not know why a list of therapeutic diets were not posted in the kitchen.	D 309		
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: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facilty failed to assure residents received medications as ordered by a licensed prescribing practitioner for 5 of 8 residents.	D 358		

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D 358	Continued From page 18 (Residents #4, #5, #6 , #2 and #3.) (Lopressor, Digoxin, Novolog, Lorazepam, and Metformin.) The findings are: A. Observation of the noon medication pass on 01/27/15 and the morning medication pass on 01/28/15 revealed 3 of 5 residents received late or incorrect medications for 31 medication observations. 1. Review of Resident #4's current FL2 dated 09/30/14 revealed: - Diagnoses of diabetes mellitus, mild mental retardation and psychosis. - An order for finger stick blood sugars (FSBS) 4 times a day with Novolog insulin for sliding scale insulin coverage. (Novolog Flexpen insulin is a quick acting insulin used to lower blood sugar levels around meal times.) - Medication orders for Novolog Flexpen 7 units before breakfast, and 14 units before lunch and supper. Interview with Staff B, Medication Aide/Supervisor at 11:40am on 01/27/15 revealed lunch was served in the facility at 12 noon. Attempted observation of a FSBS for Resident #4 on 01/27/15 at 11:45am revealed the facility had no lancets available in the facility to obtain a FSBS sample. Interview with Staff B at 11:50am on 01/27/15 revealed: - She was not comfortable giving Resident #4 her routine dose of insulin before lunch without checking her blood sugar. - Staff B was not sure if the facility had a policy about holding insulin when a FSBS could not be	D 358		

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performed.

The Administrator obtained a new lancet device and disposable lancets for Resident #4 at 12:40pm on 01/27/15.

Observation of Resident #4's FSBS at 12:43pm on 01/27/15 revealed:
- The resident's blood sugar was 169, and the resident required no sliding scale insulin. (Per physician's orders, Resident #4's sliding scale insulin started at blood sugars of 250mg/dl or greater.)
- The resident received her fixed dose of 14 units Novolog Flexpen insulin at 12:50pm, after lunch and not before as ordered.

Review of Resident #4's electronic Medication Administration Record (eMAR) revealed the fixed dose of insulin before lunch was scheduled for 11:30am.

Multiple attempts to reach the prescribing practitioner prior to exit were unsuccessful.

Per observation and record review, Resident #4 was not interviewable.

2. Review of Resident #6's current FL2 dated 01/6/15 revealed:
- Diagnoses of moderate mental retardation, speech disorder, major depression and seizure disorder.
- A medication order for Clonazepam 0.5mg 3 times a day. (Clonazepam is a medication used to treat anxiety and seizure disorders.)

Continued record review revealed:
- An order dated 01/22/15 to discontinue the Clonazepam.

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- An order dated 01/22/15 for Lorazepam 1mg 3 times a day. (Lorazepam is a medication used to treat anxiety disorders.)
- An order dated 01/22/15 for Lorazepam 0.5mg, 1 tablet daily as needed.

Observation of the morning medication pass with Staff B on 01/28/15 at 7:33am revealed Resident #6 received 5 oral medications including Lorazepam 0.5mg, but no Lorazepam 1mg.

Review of the resident's eMAR revealed:
- An entry for Lorazepam 1mg, 3 times a day, and scheduled for administration at 8am, 2pm, and 8pm.
- An entry for Lorazepam 0.5mg, 1 tablet daily as needed, with no tablets documented as administered.
- From 01/23/15 at 2pm to 01/28/15 at 8am, 15 doses of 1mg Lorazepam had been initialed as administered to Resident #6.

Observation of Resident #6's medications on hand in the medication cart at 10:30am on 01/28/15 revealed:
- A cassette of Lorazepam 0.5mg, labeled 1 tablet daily as needed, with 16 tablets dispensed on 01/22/15, and 1 tablet remaining.
- No Lorazepam 1mg tablets in the medication cart available to administer.

Observation of "overstock narcotics" in a locked file cabinet in the facility office on 01/28/15 at 11:45am revealed:
- Several cassettes of Lorazepam 1mg, labeled 1 tablet three times a day, with 90 tablets dispensed on 01/22/15.
- None of the Lorazepam 1mg tablets had been taken from the cassettes.

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Interview with the facility Director on 01/28/14 at 11:00am revealed:
- Resident #6's Lorazepam 1mg had been stored in the office.
- The medication aide on duty was supposed to put current medications into the cart when they arrived from the pharmacy.

Interview with Staff B on 01/28/15 at 11:10am revealed she did not notice the dose of routine Lorazepam on the eMAR did not match the dose on the label of Lorazepam in the medication cassette.

Interview with the dispensing pharmacist on 01/28/15 at 1:28pm revealed:
- They had dispensed 16 tablets of 0.5mg Lorazepam on 01/22/15, with directions for use of 1 tablet daily as needed.
- They had dispensed 90 tablets of 1mg Lorazepam on 01/22/15, with directions for use of 1 tablet three times a day.

Per observation and record review, Resident #6 was not interviewable.

Interview on 01/29/15 at 11:08am with Resident #6's guardian and family member revealed:
- She visits Resident #6 once or twice weekly.
- She had noticed a little increase in Resident #6's agitation over the past week.
- Resident #6 had not had any recent seizure activity.

Multiple attempts to reach the prescribing practitioner prior to exit were unsuccessful.

Review of Resident #6's eMAR from January 2015, the narcotic count sheet for the Lorazpam 0.5mg, observation of the Lorazepam 0.5mg and

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1mg on hand for administration, observation of a medication pass, and interview with Staff B, revealed Resident #6 received 15 incorrect doses of Lorazepam 0.5mg for Lorazepam 1mg from 01/23/15 at 2pm through 01/28/15 at 8am.

3. Review of Resident #5's current FL2 dated 09/19/14 revealed:
- Diagnoses of mild intellectual disability, obesity, and diabetes mellitus.
- A medication order for Metformin XR 500mg, 4 tablets daily. (Metformin XR is an extended release formulation of a medication used to treat diabetes.)

Review of a signed physician's order sheet dated 09/30/14 revealed:
- An order to discontinue the Metformin XR.
- Another medication order to start Metformin 1gm twice daily.

Review of a physician progress note dated 10/28/14 confirmed Resident #5's dose of Metformin as 1gm twice daily, not 4 tablets of XR 500mg, once daily.

Observation of the morning medication pass on 01/28/15 at 7:55am revealed:
- Resident #5 received 12 separate oral medications including 4 tablets of Metformin XR 500mg.
- The resident did not receive Metformin 1gm.

Review of Resident #5's January 2015 eMAR revealed:
- An entry for Metformin XR 500mg 4 tablets daily and scheduled for administration at 8am.
- No entry for Metformin 1gm twice daily.
- The Metformin XR 500mg had been initialed as administered daily for the month of January 2015.

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D 358	Continued From page 23 Review of Resident #5's medications on hand on the morning of 01/28/15 revealed: - Metformin XR 500mg tablets available to administer. - No Metformin 1gm tablets available to administer. Interview with the facility Director on 01/28/15 at 10:15am revealed: - She was responsible for faxing physician orders written in the facility to the pharmacy. - If the physician e-prescribed the medication, the pharmacy sent a copy back to the facility for the resident's record. Interview with Resident #5 on 01/28/15 at 1:58pm revealed she was not sure what medications she took. Interview with the pharmacist at the dispensing pharmacy on 01/28/15 at 1:28pm revealed the only Metformin order they had on file for Resident #5 was XR 500mg, 4 tablets daily. Multiple attempts to reach the prescribing practitioner prior to exit were unsuccessful. Resident #5 received the wrong dose of Metformin from 09/30/14 through 01/28/15. B. Record review of Resident #2's FL2 dated 12/16/14 revealed: - Diagnoses that included high blood pressure. - Orders for Metoprolol 25mg twice a day (used to treat high blood pressure). Further record review of a hospital discharge summary dated 01/09/15 revealed:	D 358		

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D 358	Continued From page 24 - Resident #2 was admitted to the hospital 01/03/15 with diagnoses that included pneumonia. - Orders for Lopressor (brand name for Metoprolol) 25mg twice a day. - Orders to hold Lopressor if SBP (systolic blood pressure) was less than 100 or if HR (heart rate) was less than 60. Review of the MAR (Medication Administration Record) for January 2015 revealed: - Metoprolol 25mg twice a day; hold if SBP less than 100 or HR less than 60, scheduled at 8:00am and 8:00pm. - The Metoprolol was documented as given twice a day as ordered but no blood pressure or pulse was documented. Interview with Staff B (Medication Aide) on 01/18/15 at 3:00pm revealed: - She had never checked Resident #2's pulse or blood pressure before giving the Metoprolol. - Vital signs were supposed to be done on residents once a month. - Staff B stated she did not realize the instructions on the MAR (to hold the medication depending on parameters) meant to check the resident's pulse and blood pressure before giving the medication. Interview with a local visiting Home Health Nurse on 01/29/15 at 3:45pm revealed: - She had assessed Resident #2's blood pressure and pulse that day. - The blood pressure was 130/90 and pulse was 90. Multiple attempts to reach the prescribing practitioner prior to exit were unsuccessful. C. Review of Resident #3's record revealed:	D 358		

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D 358	Continued From page 25 - An FL2 dated 07/14/14 with diagnoses that included dementia and mental retardation. - A Physician Order sheet dated 12/23/14 for Digoxin 125 mcg (micrograms) every day; hold if pulse is less than 60. (Digoxin is used to treat heart failure.) Review of the Medication Administration Record for January 2015 revealed: - Digoxin 125mcg documented as given every day at 8:00am. - Hold if pulse is less than 60. - No pulse recorded anywhere. Interview with Staff B (Medication Aide) on 01/18/15 at 3:00pm revealed: - She had never checked Resident #3's pulse before giving the Digoxin. - Vital signs were supposed to be done on residents once a month. - Staff B stated she did not realize the instructions on the MAR (to hold the medication depending on parameters) meant to check the resident's pulse before giving the medication. Interview with a local visiting Home Health Nurse on 01/29/15 at 3:45pm revealed: - She had assessed Resident #3's that day and the pulse was 88. Multiple attempts to reach the prescribing practitioner prior to exit were unsuccessful. _____ On 01/28/15, the facility provided the following plan of protection: - The facility Director will review all resident records and reconcile all orders with the current MARs within the next 32 hours to ensure accuracy.	D 358		

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D 358	Continued From page 26 - The facility Director will ensure all physician's orders are faxed and received immediately by the pharmacy. - The facility Director will ensure the medications orders are correctly entered on the MARs. - The facility Director will perform medication cart and MAR audits three times a week. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 19, 2015.	D 358		
D 393	10A NCAC 13F .1008 (b) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to properly store Schedule II medication under double lock and proper supervision at all times. The findings are: Record review for Resident #2 revealed an initial FL2 dated 11/21/14 with diagnoses that included wound cellulitis.	D 393		

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ALEXANDER ASSISTED LIVING	3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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D 393	Continued From page 27 Review of a physician order dated 12/02/14 revealed Percocet 5-325mg, two tabs by mouth every 6 hours PRN (as needed) for pain. (Percocet is a Scheduled II narcotic used for pain.) A telephone conversation with the Director on 12/09/14 at 11:15am revealed: - The Director called the Adult Home Specialist to report Resident #2's overstock Percocet had been "stolen". (This overstock supply was kept in a locked cabinet in the office, separate from a smaller amount that was kept on the medication cart). - The Director stated she had notified the pharmacy on 12/08/14 and the resident's physician on 12/09/14 regarding the missing narcotics. - She would report it to local law enforcement and Health Care Personal Registry today (12/09/14). Interview with the Director on 12/09/14 at 3:40pm revealed: - Approximately 200 of 240 tablets of Percocet 5-325mg, which were prescribed for Resident #2 and delivered on 12/03/14, had been "stolen" sometime between 12/05/14 and 12/6/14. - The narcotics were kept in a two drawer file cabinet in Director's office where overstock of Schedule II narcotics were stored. - The Director had met with law enforcement earlier today to report the theft. - The Director stated on Friday afternoon, 12/05/14, she allowed the facility housekeeper's son to sit in the office for several minutes while she stood in the adjoining room to talk to two residents. - The Director stated the file cabinet where the Schedule II narcotics were kept was unlocked at that time.	D 393		

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- The Director did not check the file cabinet before leaving work at 6pm on 12/05/14.
- On Saturday, 12/06/14 at or around 9:00am, Staff E had contacted the Director because Resident #2 was out of the Percocet (in the medication cart).
- Staff E needed the office keys to get the overstock Percocet from the file cabinet in the office containing overstock narcotics. (The Director was the only person with a key to the file cabinet in the office that contained the overstock narcotics.)
- The Director stated she was unable to bring the keys herself so she gave her boyfriend the keys on 12/06/14 and he brought the keys to Staff E around 12:00pm.
- Staff E contacted the Director shortly thereafter to notify her that the bag containing Resident #2's Percocet was not in the file cabinet.
- The Director stated both Staff A and Staff B (Medication Aides/MA) shared an office key and the Director had an office key in case there was a need to get overstock medications from the file cabinet.
- The Director had taken the shared office key back from Staff A and Staff B as a result of the missing narcotics.
- The Director had not screened staff for drugs since the occurance.
- Narcotics are counted daily from the medicaton cart, not from the overstock.

Interview with Staff A on 12/11/14 at 2:15pm revealed:
- Staff A had been employed as a MA at the facility for 6 years and primarily worked first shift from 6am-6pm.
- Resident #2 already had a supply of Percocet available on the medication cart so Staff A had observed Staff B placing Resident #2's overstock

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pain medications in the unlocked file cabinet on 12/03/14 between 6-8pm. (This was the facility's normal procedure to have a witness when narcotics were signed in.)
- Staff A shared an office key with Staff B, but she did not have a key to the file cabinet where the overstock narcotics and controlled substances were located.

Interview with Staff B on 12/11/14 at 2:25pm revealed:
- Staff B had been employed as a MA for approximately one year and worked varied 12 hour shifts, depending on staffing needs.
- On 12/03/14 between 6-8 pm, Staff B placed Resident #2's overstock narcotics in the unlocked two drawer file cabinet with Staff A as a witness and proceeded to lock office door after leaving office.
- Staff B stated on Saturday morning 12/06/14 between 8-8:30am, she received a text message from Staff E (MA) who reported that Resident #2 needed pain medication and Staff E was planning to climb through office window to get inside locked office to get the pain medication in the file cabinet.
- Staff B said she and Staff A (but not Staff E) shared an office key but neither had a key to the file cabinet where the overstock narcotics were stored.

Follow-up interview with Director on 12/11/14 at 3:00pm revealed:
- She had notified local law enforcement and Healthcare Personal Registry on 12/09/14.
- Pharmacy delivered more Percocet 5-325mg (120 count) to facility for Resident #2 on 12/12/14.

Review of the Controlled Substance Count Sheet

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D 393	Continued From page 30 (kept on the medication cart) for December 2014 revealed a quanity of 30 Percocet 5/325mg were available on 12/03/14. Staff E was not available for interview. Interview with Resident #2 on 01/28/15 at 3:30 pm revealed he had always received the PRN Percocet when requested. _____ A Plan of Protection was received on 12/09/14 that included: - All overstock narcotics and medications will be double locked by means of locked file cabinet in locked office. - Medications must be counted and documented by Director and medication aide when removed from overstock. - A staff meeting will be scheduled to enforce policies and consequences regarding storage of overstock controlled substances and medications. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 19, 2015.	D 393		
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:	D912		

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Based on observations, interviews, and record review, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to management of the facility, nutrition and food service, medication administration, controlled substances, infection prevention, infection prevention training, and medication aide training.

The findings are:

A. Based on observations, interviews, and record review, the Administrator failed to assure the total operation of the facility met and maintained rules related to management of the facility, nutrition and food service, medication administration, controlled substances, infection prevention, infection prevention training, medication aide training and resident rights. [Refer to Tag 176 10A NCAC 13F .0601(a) (Type A2 Violation.)]

B. Based on observations, record review and interviews, the facility failed to store and prepare food in a manner to protect from contamination. [Refer to Tag 283 10A NCAC 13F .0904(a)(2). (Type B Violation).]

C. Based on observations, record reviews, and interviews, the facilty failed to assure residents received medications as ordered by a licensed prescribing practitioner for 5 of 8 residents. (Residents #4, #5, #6 , #2 and #3.) (Lopressor, Digoxin, Novolog, Lorazepam, and Metformin.) [Refer to Tag 358 10A NCAC 13F .1004(a) (Type B Violation).]

D. Based on observations, record reviews and interviews, the facility failed to properly store

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D912	Continued From page 32 Schedule II medication under double lock and proper supervision at all times. [Refer to Tag 393 10A NCAC 13F .1008(b) (Type B Violation).] E. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing a lancing device when used for different residents for 8 of 8 sampled residents with orders for finger stick blood sugars (FSBS). (Residents #3, #4, #7, #8, #9, #10, #11, and #12.) [Refer to Tag D 932 G.S. 131D-4.4 A(b) (Type A2 Violation).] F. Based on record reviews and interviews, the facility failed to assure 1 of 1 Medication Aide staff, employed at the facility for at least one year, had completed the annual state approved infection control training. (Staff A). [Refer to Tag D 934 G.S. 131G-4.5B(a) (Type B Violation).] G. Based on observations, record reviews and interviews, the facility failed to assure 2 of 3 sampled Medication Aide staff who were hired, or began performing Medication Aides duties after 10/1/13 met the requirements for performing unsupervised Medication Aide duties. (Staff B and Staff D.) [Refer to Tag D 935 G.S. 131D-4.5B(b) (Type B Violation).]	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne	D932		

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D932	Continued From page 33 pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by:	D932		

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D932	Continued From page 34 TYPE A2 VIOLATION Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing a lancing device when used for different residents for 8 of 8 sampled residents with orders for finger stick blood sugars (FSBS). (Residents #3, #4, #7, #8, #9, #10, #11, and #12.) The findings are: Review of Resident #3's current FL2 dated 10/24/14 revealed: - Diagnoses of diabetes mellitus and mental retardation. - An order for finger stick blood sugars 4 times a day with sliding scale insulin coverage. - No diagnosis of a blood born infectious disease. Review of Resident #4's current FL2 dated 09/30/14 revealed: - Diagnoses of diabetes mellitus, mild mental retardation and psychosis. - An order for finger stick blood sugars 4 times a day with sliding scale insulin coverage. - No diagnosis of a blood born infectious disease. Review of Resident #7's current FL2 dated 09/30/14 revealed: - Diagnoses of diabetes mellitus type II and dementia. - An order for finger stick blood sugars every Saturday. - No diagnosis of a blood born infectious disease. Review of Resident #9's current FL2 dated 02/28/14 revealed: - Diagnoses of non-insulin dependent diabetes	D932		

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mellitus, schizoaffective disorder, and dementia.
- An order for finger stick blood sugars once a month.
- No diagnosis of a blood born infectious disease.

Review of Resident #8's current FL2 dated 01/06/15 revealed:
- Diagnosis of schizoaffective disorder.
- An order for finger stick blood sugars twice weekly before breakfast.
- No diagnosis of a blood born infectious disease.

Review of Resident #10's current FL2 dated 09/18/14 revealed:
- Diagnoses of schizoaffective disorder bipolar type, borderline personality disorder and type II diabetes.
- An order for finger stick blood sugars twice daily.
- No diagnosis of a blood born infectious disease.

Review of Resident #12's current FL2 dated 09/30/14 revealed:
- Diagnoses of mental retardation and type II diabetes mellitus.
- An order for finger stick blood sugars twice daily on Sunday and Thursday.
- No diagnosis of a blood born infectious disease.

Review of Resident #11's current FL2 dated 09/30/14 revealed:
- Diagnoses of mental retardation, personality disorder, schizophrenia and morbid obesity.
- An order for finger stick blood sugars twice weekly on Sunday and Thursday.
- No diagnosis of a blood born infectious disease.

Further record review revealed a physician progress note dated 11/18/14 with diagnosis of diabetes type II.

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D932	Continued From page 36 Attempted observation of a FSBS for Resident #4 on 01/27/15 at 11:45am revealed the facility had no lancets available in the facility to obtain a FSBS sample. Per observation on 01/27/15 at 11:45am, all residents had their own blood glucose meters and they were labeled with their names. Interview with Staff B, Medication Aide/Supervisor on 01/27/15 at 11:50am revealed: - All residents have their own glucose meters and staff do not share residents' meters. - The facility did not have any lancets available to use with the lancet pen used to obtain residents' FSBS. - The facility had only one lancet pen available in the facility and it was used on all the residents who had orders for FSBS. - Until two to three weeks ago, the facility used disposable lancet devices to obtain blood samples for the FSBS. - Staff B was not sure why they stopped using the disposable lancet devices and started using the common lancet pen. Interview with Staff A, Medication Aide/Supervisor, on 01/29/15 at 9:10am revealed: - Medication Aide staff had been using the common lancet pen for about two weeks. - Prior to the common lancet pen, they used disposable lancet devices to obtain blood samples for FSBS. - She cleaned the device with an alcohol swab and believed that would sanitize the lancet pen. - She was told by the facility Director to use the common lancet pen. Interview with Staff C, Medication	D932		

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D932	Continued From page 37 Aide/Supervisor, on 01/27/15 at 8:35pm revealed: - Medication Aide staff had been using the common lancet pen "about a week." - She used a new lancet needle in the common lancet pen each time she obtained a FSBS. - She sanitized the common lancet pen with an alcohol swab. - The facility Director told Staff C to use the common lancet pen and sanitize it with an alcohol pad. - Prior to having the common lancet pen, she used disposable lancet devices to obtain blood samples for FSBS. - She used the common lancet pen for all residents in the facilty who had orders for FSBS. Interview with the facility Administrator on 01/28/15 at 3:52pm revealed he believed staff were using disposable lancet devices to obtain FSBS. Interview with the facility Director on 01/28/15 at 3:55pm revealed: - She believed it was "OK" to use lancet pens on more than one resident as long as they were disinfected with a bleach solution. - She tried to keep a bleach solution mixed up in the med room. Interview with the pharmacist as the dispensing pharmacy on 01/28/15 revealed: - They don't currently stock disposable lancet devices due to non-payment by insurance providers. - The pharmacy stopped sending disposable lancet devices to the facility on 01/16/15. Review of the facility's policy and procedure for infection prevention in the use of point of care testing revealed:	D932		

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D932	Continued From page 38 - A disposable single-use, auto-disabling lancet is the only type of device that should be used when performing finger sticks in the center. - Lancets should never be reused. _____ On 01/27/15 the facility provided the following plan of protection: - The Administrator made an immediate purchase of 2 lancet devices with two boxes of lancets, (for the 2 residents with sliding scale insulin orders.) - Facility contacted the dispensing pharmacy, and an order of disposable lancets or lancet devices will be sent to the home by 3:00pm to 3:30pm this evening. - No lancet devices will be shared between residents. - Facility will ensure single use lancet devices are available, or a device for each resident labeled with their name. - Facility will schedule an inservice with staff beginning on 01/27/15. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 04, 2015.	D932		
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	D934		

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D934	Continued From page 39 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 record reviews and interviews, the facility failed to assure 1 of 1 Medication Aide staff, employed at the facility for at least one year, had completed the annual state approved infection control training. (Staff A). The findings are: Review of Staff A's employment records revealed: - Staff A was hired on 12/04/08 as a Medication Aide and Personal Care aide. - Staff A's medication clinical skills checklist was completed by the facility Registered Nurse (RN) on 02/12/09. - Staff A passed the medication aide test on 11/04/09. - Staff A had no documentation of completing the state approved infection control training. Interview with Staff A on 01/29/15 at 9:10am revealed: - She had worked at the facility as a Medication Aide "about 4 years." - She never had any specific training on infection control at the facility.	D934		

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D934	Continued From page 40 - She used a single lancet pen on multiple residents because the facility ran out of the disposable lancets "about 2 weeks ago." - The facility Director told her to use the common lancet pen, and to disinfect it with an alcohol swab. Interview with the facility Director on 01/28/15 at 3:55pm revealed: - She thought it was "OK" to reuse the lancet pen on multiple residents as long as they were disinfected with a bleach solution. Interview with the facility Director and Administrator on 01/29/15 at 11:15am revealed neither of them were sure if staff had completed the staff approved infection control training. Interview with the facility Director on 01/29/15 at 2:03pm revealed she had scheduled the infection control training twice with the facility Registered Nurse (RN), but she (the RN) had cancelled. Interview with the facility RN on 01/30/15 at 4:03pm revealed: - She did some infection control training with staff during the clinical skills validation and the 5 and 10 hour medication training. - She told staff not to share lancet devices or blood glucose meters. - She believed the facility Director had asked her to perform the infection control training previously, but was not sure of the date. Interview with the facility Director on 02/02/15 at 11:30am revealed: - She had been employed by this facility for less than 1 year. - She had infection control training at another facility but not this one.	D934		

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	hal002004	A. BUILDING: _____ B. WING _____	R 02/02/2015

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D934	Continued From page 41 - She worked occasionally as a Medication Aide in the facility when needed. _____ On 02/02/15 the facility provided the following plan of protection: - The facility Director will print out the state approved infection control course. - All Medication Aides will review the course and sign a form stating they have received the information in the course as soon as possible, (02/02/15). - An infection control training by the facility RN is scheduled for all facility staff on 02/17/15. THE DATE OF CORRECTION FOR THIS B VIOLATION SHALL NOT EXCEED MARCH 19, 2015.	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	D935		

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D935	Continued From page 42 Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure 2 of 3 sampled Medication Aide staff who were hired, or began performing Medication Aides duties after 10/01/13 met the requirements for performing Medication Aide duties. (Staff B and Staff D.) The findings are: A. Review of Staff D's employment records revealed:	D935		

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D935	Continued From page 43 - A hire date of 09/26/14 with the position noted as Personal Care Aide and Medication Aide. - Her medication skills checklist was completed by a Registered Nurse (RN) on 09/29/14. - No documentation of completion of the 5 hour or 10 hour training. - No documentation of passage of the state Medication Aide exam. Interview with the facility Director on 01/29/15 at 3:17pm revealed: - Staff D was waiting to take the Medication Aide exam next month. - The Director was not aware of how long Medication Aides had to take the exam after their medication clinical skills validation was completed by the RN. - Staff D initially worked as a Personal Care Aide, but had recently been working as a Medication Aide on second shift, (6pm to 6am.) Review of the facility employee schedule revealed Staff D was scheduled to work as the second shift Medication Aide/Supervisor 7 days out of 14 from 01/23/15 through 02/05/15. Attempts to interview Staff D were unsuccessful. B. Review of Staff B's employment records revealed: - A hire date of 07/19/13 as a Personal Care Aide. - A change in position to Medication Aide on 07/11/14. - Documentation of completion of the 5 hour medication training on 07/11/14, and the 10 hour medication training on 08/22/14. - Staff B's medication clinical skills validation was completed by the facility RN on 07/11/14. - No documentation of passage of the state Medication Aide exam.	D935		

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D935	Continued From page 44 Interview with the facility Director on 02/02/15 at 11:35am revealed: - Staff B was waiting to take the Medication Aide exam at the end of the month. - The director was not sure how long Medication Aides had to take the exam after the medication clinical skills validation was completed by the RN. - Staff B had never worked in another facility as a Medication Aide. - Staff B was pulled from the medication cart effective 02/02/15 until she passed the Medication Aide exam. Review of the facility employee schedule revealed Staff B had been scheduled to work as the first shift (6am to 6pm) Medication Aide/Supervisor for 7 days out of 14 from 01/23/15 through 02/05/15. Staff B was observed administering medications at 11:45am on 01/27/15 and 7:33am on 01/28/15. _____ On 01/29/15, the facility provided the following plan of protection: - Medication Aides will have all required training within 14 days from today, or they will be removed from that position until the training is obtained. - Medication Aides that have not passed the Medication Aide exam will not pass medications. - Medication Aide staff will have inservices scheduled with the consultant RN as well as the pharmacy RN. - These inservices will use local mental health staff to assist in understanding the rules and regulations as they apply to being a Medication Aide. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 19,	D935		

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D935	Continued From page 45 2015.	D935		