STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL017054	B. WING			R 15/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
CASWEL	L HOUSE		IIGHWAY 158 VILLE, NC 27	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	Annual, Follow-up a	ensure Section conducted an and Complaint Investigation 2015, June 12, 2015 and				
D 139	39 10A NCAC 13F .0407(a)(7) Other Staff Qualifications		D 139			
	(a) Each staff perso	07 Other Staff Qualifications on at an adult care home shall: background check in S. 114-19.10 and 131D-40;				
	failed to assure 1 or a criminal backgrou	et as evidenced by: and record review, the facility f 6 staff persons sampled had and check in accordance with 131D-40. (A). The findings				
	- Staff A was hired aide and personal conding to the accurrently lived in an A state criminal high dated 5/13/15 was	application for hire, Staff A other state. istory background check in the record. cumentation of a nationwide				
	Executive Director of Staff A currently licommuted to this far Only a statewide check had been controlled to the control	ved in another state and acility for work. criminal history background				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		HAL017054	B. WING		06/1	5/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CASWEL	L HOUSE		GHWAY 158 ILLE, NC 21			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION)NI	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 139	Continued From pa	ge 1	D 139			
	been responsible for were completed. - The ED and the r manager/administra	iness office manager had or ensuring staff qualifications new interim business office ator were currently responsible ns and would obtain a or Staff A.				
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident		D 164			
	Diabetic Residents An adult care home the care of resident unlicensed staff pric insulin as follows: (1) Training shall b nurse, registered pl practitioner. (2) Training shall ir (a) basic facts abo in the management (b) insulin action; (c) insulin storage; (d) mixing, measur for insulin administr (e) treatment and p and hyperglycemia, symptoms; (f) blood glucose m precautions; (g) universal preca (h) appropriate adm (i) sliding scale ins	ring and injection techniques ration; prevention of hypoglycemia including signs and monitoring; universal utions; ministration times; and ulin administration.				
	This Rule is not me Based on observati	et as evidenced by: on, interview and record				

6899

Division of Health Service Regulation STATE FORM

260C11 If continuation sheet 2 of 18

IT OF DEFICIENCIES	(VA) DDOV/IDED/OLIDDLIED/OLIA				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL017054	B. WING		R 06/15/2015	
PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
I HOUSE	535 US HI	GHWAY 158	WEST		
L HOUSE	YANCEYV	ILLE, NC 27	7379		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
Continued From page 2		D 164			
medication aides (S had completed trair resident prior to the findings are:	Staff A, C, E and F)sampled ning on the care of the diabetic administration of insulin. The				
revealed: - Staff A was hired aide (MA) and pers - There was no do state 5 hour or the administration traini - There was no do medication administration the record There was no door	on 5/18/15 as a medication onal care aide. cumentation of completing the 15 hour medication ing course in the record. cumention of completing the tration written examination in cumentation of training on the				
Review of medication administration records (MAR) for May 2015 and June 2015 revealed: - Staff A had obtained finger stick blood sugar checks and administered insulin for at least one sampled resident in the special care unit.					
revealed: - Staff A had been working in this facilit - She had been consugar monitoring ar facility since hire Staff A had some administration and not remember when - The MA had some training at this facilit training program.	a MA in another state prior to by. mpleting fingerstick blood and injecting insulin in the training in medication the care of diabetics but could in it was completed. The medication administration by with the facility's computer				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa review, the facility fa medication aides (S) had completed train resident prior to the findings are: 1. Review of the endication and personal of the service of the endication of the service of the endication administration training. There was no documedication administration administration and service of the diabetic of the	PROVIDER OR SUPPLIER STREET ADD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 review, the facility failed to assure 4 of 4 medication aides (Staff A, C, E and F)sampled had completed training on the care of the diabetic resident prior to the administration of insulin. The findings are: 1. Review of the employee record for Staff A revealed: - Staff A was hired on 5/18/15 as a medication aide (MA) and personal care aide There was no documentation of completing the state 5 hour or the 15 hour medication administration training course in the record There was no documention of completing the medication administration written examination in the record There was no documentation of training on the care of the diabetic resident in the record. Review of medication administration records (MAR) for May 2015 and June 2015 revealed: - Staff A had obtained finger stick blood sugar checks and administered insulin for at least one sampled resident in the special care unit. Interview with Staff A on 6/15/15 at 4:05 p.m. revealed: - Staff A had been a MA in another state prior to working in this facility She had been completing fingerstick blood sugar monitoring and injecting insulin in the facility since hire Staff A had some training in medication administration and the care of diabetics but could not remember when it was completed The MA had some medication administration training at this facility with the facility's computer	HALO17054 B. WING STREET ADDRESS, CITY, S. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 review, the facility failed to assure 4 of 4 medication aides (Staff A, C, E and F)sampled had completed training on the care of the diabetic resident prior to the administration of insulin. The findings are: 1. Review of the employee record for Staff A revealed: - Staff A was hired on 5/18/15 as a medication aide (MA) and personal care aide. - There was no documentation of completing the state 5 hour or the 15 hour medication administration training course in the record. - There was no documentation of training on the care of the diabetic resident in the record. - There was no documentation of training on the care of the diabetic resident in the record. - There was no documentation of training on the care of the diabetic resident in the record. Review of medication administration records (MAR) for May 2015 and June 2015 revealed: - Staff A had obtained finger stick blood sugar checks and administered insulin for at least one sampled resident in the special care unit. Interview with Staff A on 6/15/15 at 4:05 p.m. revealed: - Staff A had been a MA in another state prior to working in this facility. - She had been completing fingerstick blood sugar monitoring and injecting insulin in the facility since hire. - Staff A had some training in medication administration and the care of diabetics but could not remember when it was completed. - The MA had some medication administration training program.	HAL017054 STREET ADDRESS, CITY, STATE, ZIP CODE S35 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379 SUMMARY STATEMENT OF DEFCIENCIES (EACH DEFICIENCY) MUST BE PRECEDED BY VILL (REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 review, the facility failed to assure 4 of 4 medication aides (Staff A, C, E and F)sampled had completed training on the care of the diabetic resident prior to the administration of insulin. The findings are: 1. Review of the employee record for Staff A revealed: 2. Staff A was hired on 5/18/15 as a medication aide (MA) and personal care aide. 3. There was no documentation of completing the medication administration written examination in the record. 4. There was no documentation of training on the care of the diabetic resident in the record. 5. There was no documentation of training on the care of the diabetic resident in the record. 6. There was no documentation of training on the care of the diabetic resident in the record. 7. There was no documentation of training on the care of the diabetic resident in the special care unit. 8. Interview with Staff A on 6/15/15 at 4:05 p.m. revealed: 9. Staff A had been a MA in another state prior to working in this facility. 9. She had been completing fingerstick blood sugar monitoring and injecting insulin in the facility since hire. 9. Staff A had some training in medication administration and the care of diabetics but could not remember when it was completed. 1. The MA had some medication administration training at this facility with the facility's computer training program.	HALO17054 STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 review, the facility failed to assure 4 of 4 medication aides (Staff A, C, E and F)sampled had completed training on the care of the diabetic resident prior to the administration of insulin. The findings are: 1. Review of the employee record for Staff A revealed: 2. Staff A was hired on 5/18/15 as a medication aide (MA) and personal care aide. 1. There was no documentation of completing the state 5 hour or the 15 hour medication administration written examination in the record. 2. There was no documentation of training on the care of the diabetic resident in the record. 3. There was no documentation of training on the care of the diabetic resident in the record. 4. There was no documentation of training on the care of the diabetic resident in the record. 5. There was no documentation of training on the care of the diabetic resident in the record. 6. There was no documentation of training on the care of the diabetic resident in the record. 7. There was no documentation of training on the care of machine training insulin for at least one sampled resident in the special care unit. 1. Interview with Staff A on 6/15/15 at 4:05 p.m. revealed: 5. Staff A had been a MA in another state prior to working in this facility. 5. Staff A had some training in medication administration and the care of diabetics but could not remember when it was completed. The MA had some medication administration raining at this facility with the facility's computer training program.

DIVISION	Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL017054	B. WING		R 06/15/2015		
NAME OF I	PROVIDER OR SUPPLIER	STDEET VUI	DESS CITY S	STATE, ZIP CODE	-		
NAME OF	NOVIDEN ON SOIT EIEN		GHWAY 158				
CASWELL HOUSE		ILLE, NC 27					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
D 164	Continued From pa	ge 3	D 164				
	Regional Nurse.						
	Refer to interview on 6/15/15 at 3:40 p.m. with the Executive Director.						
	 2. Review of the employee record for Staff C revealed: Staff C was hired on 5/29/15 as a medication aide (MA) and personal care aide. There was no documention of completing the MA qualification of training on the care of the diabetic resident. 						
	Observation on 6/12/15 at 11:35 a.m. of Staff C, medication aide (MA) during the morning medication pass revealed: - Staff C administered medications to 4 assisted living (AL) residents She performed a finger stick blood sugar check on 1 of 4 residents at 11:35 am and administered Novolog (insulin) 10 units subcutaneously to the resident at 1:00 p.m. after the resident had eaten lunch as per physician order.						
	MA, revealed: - She administered finger stick blood suinsulin to residents - Staff C stated have 10 hr. facility computed medication aides for Staff C also state	5 at 9:20 a.m. with Staff C, I medications, performed ugar checks, and administered as ordered by physicians. ving completed a 5 hr. and a uter training course for or orientation as a MA. d being "an experienced MA" (state medication aide) test a					
	Refer to interview o Regional Nurse.	n 6/15/15 at 3:30 p.m. with the					

Refer to interview on 6/15/15 at 3:40 p.m. with the

STATE FORM 6899 If continuation sheet 4 of 18 260C11

DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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			B. WING		F	
		HAL017054	B. WING		06/1	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			IGHWAY 158			
CASWEL	L HOUSE					
		TANCET	ILLE, NC 2	7379		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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IAG			IAG	DEFICIENCY)	=	
D 164	Continued From pa	ge 4	D 164			
	Executive Director.					
	Executive Director.					
	3. Review of the employee record for Staff E					
	revealed:	ipioyee record for Staff L				
		on 2/04/13 as a medication				
	aide (MA).	on 2/04/13 as a medication				
		cumentation in the record of				
		of training on the care of the				
	the diabetic resident.					
	Review of medication administration record for					
		d Staff E had obtained				
		gar (FSBS) monitoring and				
	administered insulir	i during the month.				
	Observation during	the 12 near medication need				
		the 12 noon medication pass				
		ff E revealed she obtained a				
		ered insulin by injection to a				
	resident as ordered					
	lata a la company 0/40/4	5 -1 40-40				
		5 at 12:40 p.m. with Staff E				
	revealed:	ad to the feetite and AA fee O				
		ed in the facility as a MA for 2				
	years.	and the initial in the facility.				
		ome training in the facility				
		d but could not remember any				
		raining except some				
	information about ti	ne insulin injection pens.				
	Defende intensions	- C/45/45 -4 2:20ith the				
		on 6/15/15 at 3:30 p.m. with the				
	Regional Nurse.					
	Defenda internilerre	m C/4E/4E at 2:40 in the state the				
		on 6/15/15 at 3:40 p.m. with the				
	Executive Director.					
	4 Davida - fills	and a second for Otal				
		nployee record for Staff F				
	revealed:	10/00/10				
		on 10/29/13 as a medication				
	aide (MA).					
	 There was docun 	nentation Staff F had				

STATE FORM 6899 If continuation sheet 5 of 18 260C11

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPL	E CONSTRUCTION	(X3) DATE	CLID\/EV
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			LETED
			A. DUILDING:			
		1141 047054	R WING		F	
		HAL017054	D. WING		06/1	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CASME	L HOUSE	535 US H	GHWAY 158	WEST		
CASWE	LL HOUSE	YANCEYV	ILLE, NC 27	7379		
(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 164	Continued From page 5		D 164			
	completed the MA t - There was docum medication adminis 11/24/08 There was no doo of training on the car Observation on 6/12 during the afternoon Staff F performed fi on 2 residents who scale insulin. Staff F was not ava Refer to interview or Regional Nurse.	raining. nentation passing the tration written test on cumention of MA qualification are of the diabetic resident. 2/15 at 4:10 pm of Staff F, MA, n medication pass revealed nger stick blood sugar checks required no insulin for sliding ilable for interview. n 6/15/15 at 3:30 p.m. with the				
	Refer to interview on 6/15/15 at 3:40 p.m. with the Executive Director. Interview on 6/15/15 at 3:30 p.m. with the Regional Nurse revealed: - She thought the company's computer training completed would have covered the diabetic training The Regional Nurse was not aware of the MA qualification of Training on the Care of the Diabetic Resident prior to administering insulin. Interview on 6/15/15 at 3:40 p.m. with the Executive Director (ED) revealed: - The Business Office Manager and the Administrator would be responsible for ensuring medication aides (MA) had the required training She was not aware of the MA qualification of Training on the Care of the Diabetic Resident prior to administering insulin.					

Division of Health Service Regulation

STATE FORM 6899 260C11 If continuation sheet 6 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.	7. Bolebino.		₹
		HAL017054	B. WING			5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CASWEL	L HOUSE		GHWAY 158 ILLE, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 164	Continued From pa	ge 6	D 164			
	was all the medication training medication aides needed. - She would put a system in place to ensure all MA required training including the diabetic training was completed.					
D 468	68 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train		D 468			
	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training					
	receive at least the training: (1) Prior to establis administrator shall a 20 hours of training be served for each operated. The administrator shall a served for each operated. The administrator of the sidentifies content, to schedules regarding (2) Within the first employee assigned special care unit shorientation on the nine residents. (3) Within six montresponsible for perswithin the unit shall specific to the populate the training and of Rule .0501 of this sof orientation requires (4) Staff responsible supervision within the population of continuation of continuat	sure that special care unit staff following orientation and shing a special care unit, the document receipt of at least specific to the population to special care unit to be ninistrator shall have in place a taff assigned to the unit that exts, sources, evaluations and g training achievement. Week of employment, each to perform duties in the all complete six hours of ature and needs of the this of employment, staff sonal care and supervision complete 20 hours of training lation being served in addition competency requirements in Subchapter and the six hours red by this Rule. He for personal care and the unit shall complete at least ing education annually, of all be dementia specific.				

6899

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		1101 047054	B. WING		R 06/15/2015	
		HAL017054	D:		06/1	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		535 US H	IGHWAY 158	WEST		
CASWEL	L HOUSE		ILLE, NC 2			
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	-	(X5) COMPLETE
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				DEFICIENCY)		
D 400	0 " 15	_	D 400			
D 468	8 Continued From page 7		D 468			
	This Rule is not me	et as evidenced by:				
		ion, interview and record				
		ailed to assure special care				
		S hours orientation within the				
		yment and/or 20 hours of				
	training within 6 months related to the population served for 4 of 5 sampled special care unit staff. (B, C, D, and E). The findings are:					
	1 Review of the em	nployee record for Staff E				
	revealed:	iployee record for Gtan E				
		on 2/04/13 according to the				
	application for hire.					
		a nursing assistant and				
		the special care unit (SCU).				
		cumentation of 6 hours				
		SCU in the first week of				
	employment.	oco in the mst week of				
		hours of of SCII training was				
	completed by 7/15/	hours of of SCU training was				
		U training was documented				
		s from employment from				
	11/11/13 - 12/02/13					
		cumentation of the 20 hours of			ļ	
		d of SCU training were not			ļ	
	completed within 6	months of employment.				
	Deview of the facilit	ty staffing schedule revealed				
	6/11/15 and 6/12/15	orking in the SCU on 6/10/15,			ļ	
	0/11/13 and 0/12/13	J.				
	Observation on 6/4	0/15 6/12/15 and 6/15/15			ļ	
		0/15, 6/12/15 and 6/15/15				
		as passing medications to			ļ	
	residents in the SC	U.				
	Defenda internite	OMEME ALOMO TO THE WAY			ļ	
		on 6/15/15 at 3:40 p.m. with the				
	Executive Director.					

6899

Division	Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL017054	B. WING		R 06/15/2015		
NAME OF I		CTDEET AD		TATE ZID CODE			
NAIVIE OF I	PROVIDER OR SUPPLIER		IGHWAY 158	STATE, ZIP CODE			
CASWEL	L HOUSE		ILLE, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
D 468	Continued From pa	ge 8	D 468				
	revealed: - Staff B was hired assistant During the first we had 10 hours of special orientation No other training in the record. Review of the facilit Staff B worked in the 6/12/15. Refer to interview of Executive Director. 3. Review of the errevealed: - There was no doo Staff D A criminal backgrifor staff D was date Staff D was hired There was docum care unit (SCU) orientie to work in the Schot of 6 hours SCU There was not 20 months for the SCU. Review of the facilit Staff S worked 6/10 the special care unit.	as a nursing assistant. nention of 10 hours of special entation in the first week of SCU. ining was documented as 3/14, 2/11/14 and 2/17/14 for a J training. I hours of training within 6 J in the record. by's staffing schedule revealed 1/15 as a nursing assistant in					
	Executive Director	5, 15, 15 at 5.45 p.m. with the					

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		HAL017054	B. WING		06/15/2015	
NAME OF I	PROVIDER OR SUPPLIER	CTDEET AD	DDESS CITY O	STATE, ZIP CODE		
NAIVIE OF I	FROVIDER OR SUFFLIER					
CASWEL	L HOUSE		GHWAY 158			
	T		ILLE, NC 27			T.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 468	Continued From pa	ge 9	D 468			
	revealed: - Staff C was hired special care unit (S areas of the facility nursing assistant There was no do orientation in the fir SCU. Review of the staff Staff C was schedu first shift as a nursing Refer to interview of Executive Director - The Business Off Administrator/ED wensuring all staff has working in the special audits since a chain Administrator to ensure completed She thought the Staff working - The ED thought the staff was completed as a Further employed.	on 6/15/15 at 3:40 p.m. with the 5 at 3:40 p.m. with the (ED) revealed: fice Manager (BOM) and the rould be responsible for ad the required training for aial care unit (SCU). Congoing employee record ge over of BOM, ED and sure all training qualifications SCU training was completed in the SCU. he facility's computer training				
D934	G.S. 131D-4.5B. (a Requirements) ACH Infection Prevention	D934			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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		HAL017054	B. WING		06/1	5/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S GHWAY 158	STATE, ZIP CODE		
CASWEI	L HOUSE		ILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D934	G.S. 131D-4.5B Ad Prevention Require (a) By January 1, 2 Service Regulation annual in-service tr home medication a practices for injectic during which bleedi glucose monitoring successfully comple program shall recei determined by the I continuing education and prevention of the service of	ult Care Home Infection	D934			
	review, the facility finandatory, annual adult care home more control had been comedication aides. (are: 1. Review of the errevealed: - There was no hire A facility application of the errevealed: - Staff E was hired medication aide A state mandator course had been comedication.	et as evidenced by: on, interview and record ailed to assure the state in-service training program for edication aides on infection ompleted for 2 of 4 sampled Staff E and F). The findings mployee record for Staff E e date listed for Staff E. on for hire was dated 2/04/13. as a nursing assistant and by annual infection prevention ompleted on 3/14/14. etion control certificate was in				

Division of Health Service Regulation

Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					_	
			D WINC		R	
		HAL017054	B. WING		06/1	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TO WILL OF I	NOVIDEN ON OUT LIEN					
CASWEL	L HOUSE		IGHWAY 158			
		YANCEY	/ILLE, NC 27	7379		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				BEI IOIEROT)		
D934	Continued From pa	ae 11	D934			
	•					
		documentation of the state				
	mandatory annual infection prevention course in the record.					
	Interview on 4/22/1	5 at 3:40 p.m. with the				
	company's regional	nurse revealed:				
	- The facility's com	pany had training for infection				
	control by compute					
		aken by the medication aide				
		te was printed from the				
		and the nurse trainer would				
	sign it as completed					
		re this was not the state				
	mandatory annual t					
	prevention.	laning for infection				
	prevention.					
	Defer to interview of	on 6/15/15 at 3:30 p.m. with the				
		11 0/15/15 at 5.50 p.111. with the				
	Regional Nurse.					
	Defeate intensions	n C/15/15 at 2:40 n mith tha				
		on 6/15/15 at 3:40 p.m. with the				
	Executive Director.					
		mployee record for Staff F				
	revealed:					
		on 10/29/13 as a medication				
	aide (MA).					
		nentation Staff F had				
	completed the MA t					
		nentation passing the				
		tration written test on				
	11/24/08.					
	- The last infection	control class taken was dated				
	11/12/13.					
	- There was no doo	cumentation of the mandatory				
		on prevention course in the				
	record.					
	Observation on 6/1	2/15 at 4:10 pm of Staff F, MA,				
		n medication pass revealed				
		inger stick blood sugar checks				
	Otali i periorifica ii	inger stick blood sugar criccits				

STATE FORM 6899 If continuation sheet 12 of 18 260C11

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
			A. BUILDING:		ь		
HAL017054		B. WING		R 06/15/2015			
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CASWEL	L HOUSE		GHWAY 158 ILLE, NC 27				
(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 12		D934				
	on 2 residents who required no insulin for sliding scale insulin at that time.						
	Staff F was not ava	ilable for interview.					
	Refer to interview on Regional Nurse.	on 6/15/15 at 3:30 p.m. with the					
	Refer to interview on 6/15/15 at 3:40 p.m. with the Executive Director. Interview on 6/15/15 at 3:30 p.m. with the Regional Nurse revealed she thought the company's computer training completed with their nurse signing a certificate afterward that the MA had completed the company training would be accepted.						
	Interview on 6/15/15 at 3:40 p.m. with the Executive Director (ED) revealed: - The Business Office Manager and the Administrator and ED would be responsible for ensuring medication aides (MA) had the required training. - The ED thought the facility's company training was all the medication training medication aides needed. - Employee record audits had been completed to ensure all staff qualification were met since a change over in management staff some months ago. - The ED thought all MA had required training. - The facility would put a system in place to ensure all MA required training was completed.						
D935	935 G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency		D935				

DIVISION	of Health Service Re	guiation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					F	,
HAL017054		B. WING		06/15/2015		
NAME OF F				OTATE ZID CODE		0.2010
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CASWEL	L HOUSE		GHWAY 158			
,		YANCEYV	ILLE, NC 2	7379		
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D935	Continued From pa	ge 13	D935			
	Medication Aides; T Evaluation Require					
	home is prohibited to any unsupervised m	per 1, 2013, an adult care from allowing staff to perform nedication 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					
		ing program developed by the				
	in all of the following					
	a. The key principle administration.					
		ers for Disease Control and es on infection control and, if				
	procedures for mon	itoring or testing in which the potential for bleeding				
	exists.	valuation 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					
	training and instruct	epartment that includes tion in all of the following:				
	1. The key principle 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.					
		leveloped and administered				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
HAL017054		B. WING		R 06/15/2015		
CASWELL HOUSE 535 US HI			DRESS, CITY, SIGHWAY 158			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMP		(X5) COMPLETE DATE
D935	by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 2 of 4 sampled medication staff completed medication administration training and competency requirements before performing unsupervised medication aide duties. (Staff A and C). The findings are: 1. Review of the employee record for Staff A revealed: - Staff A was hired 5/18/15 as a medication aide (MA). - There was no documentation of completing the state 5 hour or the 10 hour medication administration training course in the record. - There was no documention of completing the medication administration written examination in the record. - Review of a medication clinical skills validation form dated 6/04/15 did not include a check off for administering medication via nebulizer.		D935			
	Review of medication administration records (MAR) for May 2015 and June 2015 revealed: - Staff A had obtained finger stick blood sugar checks and administered insulin for at least one sampled resident in the special care unit. - Staff A had initialed as administered other medications for two sampled residents in the special care unit. Observation on 6/14/15 during the 4:00 p.m.					
	medication pass revealed Staff A administered a nebulizer medication treatment to a resident.					

6899

CTATEMENT OF DEFICIENCIES (VA) PROVIDER/CHIPPLIED/OLIA		(V2) MULTIPL	F CONSTRUCTION	(V2) DATE	CLIDVEV	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · ·		(X3) DATE COMP	LETED	
MOTERNOT CONNECTION		A. BUILDING:				
				F		
		HAL017054	B. WING		06/1	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			GHWAY 158			
CASWEL	L HOUSE		ILLE, NC 27			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG			TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
D935	Continued From pa	ge 15	D935			
	•					
	Intorvious with Staff	A on 6/15/15 at 4:05 p.m.				
	revealed:	A 011 0/15/15 at 4.05 p.111.				
		a MA in another state prior to				
	working in this facili					
		rking as a medication aide in				
		been administering all types of				
	medication to reside					
	- Staff A had some training in medication administration since she was hired but did not know if it was the state medication administration					
	training.					
	Interview on 6/15/15 at 3:30 p.m. with t he					
		ealed Staff A had been				
		ne 5 hour and 10 hour med				
		taken the company's				
		on administration training so				
	far.					
		5 at 3:40 p.m. with the				
	Executive Director					
		Staff A was a MA in a nearby				
	in this state.	qualified to pass medications				
	- Staff A would be removed from the medication cart until the 5 hour training had been completed.					
		mpleted the rest of the training				
	required.					
		ould be put in place to ensure				
	all medication aides had completed qualifications					
	to administer medic	ation.				
	Defer to interview a	n 6/15/15 at 2:20 n m with the				
Refer to interview on 6/15/15 at 3:30 p.m. with the						
	Regional Nurse.					
	Refer to interview on 6/15/15 at 3:40 p.m. with the					
Executive Director.						

6899

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
1141 047054		B. WING		R 06/15/2015		
		HAL017054			1 06/1	5/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CASWEL	L HOUSE			_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D935	Continued From page 16		D935			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					
	Refer to interview on 6/15/15 at 3:40 n m, with th					

6899

Division of Health Service Regulation STATE FORM

Executive Director.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL				
HAL017054		B. WING			≷ 5/2015	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CASWEL	L HOUSE		GHWAY 158 ILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D935	Continued From pa	ge 17	D935			
	Regional Nurse rev company's compute nurse signing a cert had completed the accepted. Interview on 6/15/18 Executive Director (- The Business Off Administrator and Eensuring medication training. The ED thought the was all the medicat needed. Employee record ensure all staff qual change over in marago. The ED thought a The ED thought a The facility would	5 at 3:30 p.m. with the ealed she thought the er training completed with their tificate afterward that the MA company training would be 5 at 3:40 p.m. with the (ED) revealed: Fice Manager and the ED would be responsible for a aides (MA) had the required the facility's company training ion training medication aides audits had been completed to diffication were met since a magement staff some months all MA had required training. Put a system in place to red training was completed.				
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