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 _____	08/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDER ASSISTED LIVING	3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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D 000	Initial Comments The Adult Care Licensure Section and the Alexander County Department of Social Services conducted a follow-up survey and complaint investigation initiated on August 4, 2016 on August 4, 5, 8, 2016.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to clean and maintain floors in 2 of 12 occupied resident rooms (Rooms #7 and #12), 2 of 2 hallway ceiling fans, 1 of 2 common shower rooms, 1 of 1 common tub rooms and to repair walls in 2 of 12 occupied resident rooms (Rooms #7 and #9) and a broken window in 1 of 12 occupied resident rooms (Room #2). The findings are: Observation on 8/4/16 at 10:10AM of the resident hallway outside of resident room #8 revealed: -A ceiling fan that was not in operation. -The blades of the fan were covered in a thick coating of dust. Interview on 8/4/16 at 10:12AM with Staff E, Personal Care Aide (PCA) revealed: -"Recently" there had been no routinely scheduled housekeeper on day shift. -When a housekeeper was scheduled, it was for	D 074		

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D 074	Continued From page 1 2 or 3 days out of the week. -Today she was assigned housekeeping duties which included making beds, collecting trash, cleaning bathrooms, sweeping and mopping floors and cleaning the smoking porch. -There was medication aide on the medication cart and another PCA on the floor for resident care. Observation on 8/4/16 at 10:44AM of the common resident shower room in the vicinity of resident rooms #5 and #6 revealed: -A shower chair with built-up dirt and soap scum on the chair legs and brown/black residue on the underside of the chair seat and chair back. -Brown/black grout staining on the tiled shower floor and wall and dirty tiles. -Built-up dirt around the door knob and edge of bathroom door. -Cobwebs in the corners of the bathroom ceiling. Observation on 8/4/16 at 10:50AM of the common resident tub room revealed: -A step-in tub with a latching door on the side of the tub. -When the door was opened, built-up dirt was noted in the door seam and around the tub drain. -Numerous dead insects gathered in the light fixture over the mirror and sink. -A mechanical lift frame and fabric seat covered in dust. -Built-up dirt around the door knob and edge of bathroom door. Observation on 8/4/16 at 10:53AM of resident room #7 revealed: -The residents who lived in the room were not present. -The stucco walls which had numerous black scuff marks and places of chipped paint.	D 074		

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D 074	Continued From page 2 -Built-up dirt on the floor at the baseboards and at the legs of the beds. -The heater/air conditioning unit in the wall under the window had a dusty vent and dust and debris in the top of the unit. Observation on 8/4/16 at 10:58AM of resident room #9 revealed: -The light in the ceiling fan was missing the glove cover. -A wall was covered in numerous plastic mounting anchors inserted into the wall. Observation on 8/5/16 at 9:27AM of the resident hallway outside of resident room #11 revealed: -A ceiling fan that was not in operation. -The blades of the fan were covered in a thick coating of dust. Observation on 8/5/16 at 9:27AM of resident room #2 revealed: -The lower half of the window had a single pane of glass. -This pane of glass was broken in a spider web pattern, each crack was taped up with duct tape. -The amount of tape used occluded approximately 50% of the light coming through the window. -Built-up dirt on the floor at the baseboards and at the legs of the beds. -Cobwebs in a window sill and covering a stuffed animal on the sill. Interview on 8/5/16 at 9:27AM of a resident of room #2 revealed: -His roommate hit the window and broke it. -The Maintenance man taped up the window. -He could not recall how long the window had been broken or had been repaired.	D 074		

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D 074	Continued From page 3 Interview on 8/8/16 at 12:00PM with the Director revealed: -A regular housekeeper worked 8 hour shifts on Tuesdays, Wednesdays, Fridays and Saturdays. -Another staff member worked 8 hour shifts on Mondays, Thursdays, and Saturdays but sometimes she worked as a housekeeper and other times as a PCA. -Housekeeping duties included cleaning and disinfecting bathrooms, sweeping and mopping floors, picking up trash in resident rooms, wiping down handrails and dusting. -Deep cleaning occurred on third shift as "things were not that busy" and included cleaning wheelchairs, walkers and urinals. -The Maintenance man had a buffer he used on floors but there was no schedule for its use. -Ceiling fans were cleaned when they appeared dusty. -"We're working at it [overall cleaning of grout, tile and shower curtains in common shower rooms]." -If windows were broken they were repaired or replacement windows were ordered. -A window had been broken in a resident room and the Maintenance man could not fix it, but a replacement window had been ordered two weeks prior (no invoice was provided). -Staff were expected to complete a cleaning checklist (no checklist was provided). -Deep cleaning of resident rooms was not on a schedule but was completed as required.	D 074		
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff	D 150		

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D 150	Continued From page 4 who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure documentation that 3 of 9 sampled facility staff [Staff D, E, and F] who provided personal care to residents had been competency evaluated and successfully completed an 80 hour personal care training program within 6 months after hire established by the Department. The findings are: A. Review of Staff D's personnel file revealed: -A hire date of 8/28/15. -She had been hired as a Cook. -Documentation for personal care training was present. -No documention of personal care competency evaluation.	D 150		

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D 150	Continued From page 5 Attempted telephone interview with Staff D on 8/5/16 at 11:15 am was unsuccessful. B. Review of Staff E's personnel file revealed: -A hire date of 12/15/2014 -She had been hired as a Personal Care Aide. -Documentation for personal care training was present. -No documention of personal care competency evaluation. Interview with Staff E on 8/8/16 at 10:10 am revealed: -She had worked at the facility since 2014. -She had previously worked as a Personal Care Aide, but changed to housekeeping. -She was currently working in the facility as a housekeeper. -She did work as a Personal Care Aide when needed. -She had received personal care aide competency evaluation when she was hired. C. Review of Staff F's personnel file revealed: -A hire date of 8/24/15. -She had been hired as a housekeeper. -No documention of successfully completing an 80 hour personal care training course. -No documention of personal care competency evaluation. Interview with Staff F on 8/4/16 at 10:25 am revealed: -She had worked at the facility for a year. -She had worked in the facility as a housekeeper. -She had been required, occasionally, to work on the floor as a Personal Care Aide because of staff not coming into work. -She had helped residents with showers, and going to the bathroom.	D 150		

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D 150	Continued From page 6 -She had never been trained as a personal care aide. Two confidential Staff interviews revealed: -"[Staff D] had worked as a Personal Care Aide when they were short staffed." -They could not give specific dates. -"Some staff work for 3 and 4 days straight in the facility." -"There are staff who lay out of work a lot, and that is why the kitchen and housekeeping staff have to work as Personal Care Aides." Interviews with five residents on 8/5/16 revealed facility staff assisted them with bathing, assisting to the bathroom, and dressing. Interview with the Facility Director on 8/5/16 at 11:45 am revealed: -She did utilize the kitchen and housekeeping staff for personal care of residents. -She thought that under "emergency" situations she could use any staff to help with resident care. -She thought that not having enough staff to work on the shift constituted an "emergency". -She had a lot of staff that just would not come into work and then she would be short staffed. -She had notified the pharmacy, in June 2016, for the need of competency evaluation of staff, but they had not came out yet. Interview with the facility pharmacist on 8/5/16 at 9:40 am revealed: -They always went to the facility to provide competency evaluation for Personal Care Aides when contacted. -They were not aware of the facility contacting them about the need for competency evaluations. -He had been at the facility monthly for several months and no one had ever notified him of the	D 150		

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D 150	Continued From page 7 need for the competency evaluations. Interview with the Administrator on 8/8/16 at 12:00 PM revealed: -His expectation would be that all staff who work with residents be trained. -He was not aware that the personal care aide competency evaluations had not been completed. -He was aware of the staffing issues and was relying on the Facility Director to "handle it". -He did know that it was not permitted to use untrained staff for resident care, but did not know what else that could be done when staff did not show up for work.	D 150		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions;	D 164		

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D 164	Continued From page 8 (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 3 of 3 medication aides (Staff B, C, and I) sampled received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are: A. Review of Staff B's personnel file revealed: -A hire date of 6/1/16. -She was hired as a Personal Care Aide / Medication Aide. -She passed the written medication exam in 2009. -No documentation of a completed clinical medication administration validation. -There was no documentation of any diabetes training for Staff B. Attempted telephone interview with Staff B on 8/4/16 at 11:15 am was unsuccessful. B. Review of Staff C's personnel file revealed: -A hire date of 3/31/16. -She was hired as a Medication Aide. -She passed the written medication exam in 2008. -No documentation of a completed clinical medication administation validation. -There was no documentation of any diabetes training for Staff C.	D 164		

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D 164	Continued From page 9 Attempted telephone interview with Staff C on 8/5/16 at 12:15 pm was unsuccessful. C. Review of Staff I's personnel file revealed: -A hire date of 7/12/16. -She was hired as a Medication Aide. -She had not taken a medication exam. -No documentation of a completed clinical medication administration validation. -There was no documentation of any diabetes training for Staff B. Attempted telephone interviews with Staff I on 8/5/16 at 3:50 pm, 8/6/16 at 2:30 pm, and 8/7/16 at 10:00 am was unsuccessful. Review of sampled resident's medication administration records revealed Staff B, C and I did perform diabetic care [fingerstick blood sugars, and insulin administration] to residents residing in the facility. Review of a a synopses from the facility pharmacy of diabetic training class dated 6/16/16 revealed the following training: -'Signs and symptoms of DM Type 1'. -'Testing and monitoring of DM Type 1'. -'Treatment of DM Type 1'. -'Side effects of medications used to treat DM Type 1'. -'Signs and Symptoms of hypo/hyperglycemia'. -'Questions'. Interview with the Facility Pharmacist on 8/5/16 at 9:40 am revealed: -He had been doing diabetic training at the facility with the medication aides. -He had been doing the training monthly, training one topic per class. -He could not tell the names of the staff who had	D 164		

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D 164	Continued From page 10 attended the training. -He did not keep a sign-in roster. -He thought the facility was keeping a sign-in roster. Interview with the Facility Director on 8/8/16 at 12:30 pm revealed: -The Facility Pharmacist had been coming to the facility to do diabetic training monthly for several months. -There were diabetic residents in the facility, but she did not know the exact number. -There were some diabetic residents in the facility who received insulin. -All of the medication aides were receiving the diabetic training. -She did not have a sign-in roster of the medication aides who were being training. Interview with the Administrator on 8/8/16 at 12:45 pm revealed: -The Facility Director was supposed to make sure all the diabetic training had been completed and documentation in place. -He did expect for the Medication Aides to have had the diabetic training. -The Facility Pharmacist had been coming to the facility to do diabetic training.	D 164		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this	D 276		

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D 276	Continued From page 11 Rule. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to perform daily blood pressure checks as ordered for 1 of 3 residents reviewed (Resident #3). The findings are: Review of Resident #3's closed record revealed: -An admission date of 5/26/16. -A discharge date of 7/27/16 of her own choosing to a nursing home. Review of the most current FL-2 dated 5/26/16 for Resident #3 revealed: -Diagnoses included bipolar disorder and epilepsy. -No orders for antihypertensive medications. -An order for a daily blood pressure (BP) check. Review of provider progress notes for Resident #3 revealed no documentation of high or low BPs or related symptoms for the duration of her admission at the facility. Review of a hard copy of the June 2016 Medication Administration Record (MAR) for Resident #3 revealed: -An entry dated 6/3/16 for daily BP checks. -No blood pressures documented on 16 of the 30 days of the month (6/1/16 through 6/5/16, 6/7/16 through 6/12/16, 6/14/16 through 6/15/16, 6/19/16, 6/26/16 and 6/28/16). -Exception comments for the blood pressure check on 6/7/16, 6/9/16 and 6/10/16 were "not required. "	D 276		

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D 276	Continued From page 12 -An exception comment for the blood pressure check on 6/14/16 as "not required." -There were no other comments documented for the remaining days when BPs were not documented. -On the days blood pressure checks were done, the range of values was 93 to 132 mmHg (millimeters of mercury) systolic over 54 to 80 mmHg diastolic. Review of a hard copy of the July 2016 MAR for Resident #3 revealed: -An entry dated 6/3/16 for daily BP checks. -A stop date for the order of 7/27/16 (day of discharge). -No blood pressures documented on 12 of the 27 days of the month the resident was in the facility (7/1/16, 7/5/16 through 7/7/16, 7/13/16 through 7/17/16, 7/23/16 and 7/26/16). -An exception comment for the blood pressure check on 7/13/16 as "resident refused." -An exception comment for the blood pressure check on 7/23/16 as "not required." -There were no other comments documented for the remaining days where BPs were not documented. -On the days blood pressure checks were done, the range of values was 91 to 132 mmHg systolic over 64 to 86 mmHg diastolic. Telephone interview on 8/5/16 at 8:25AM of Resident #3 revealed: -She "barely" got BP checks. -Her BP was checked 3 to 4 times period." -Her BP ran "very low" and staff wanted to keep "an eye on it." -Staff knew she had felt lightheaded several times and she had "passed out" once early in her stay, being found she believed by Staff J, Medication Aide (MA).	D 276		

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D 276	Continued From page 13 Telephone interview on 8/5/16 at 3:45PM with the Nurse Practitioner revealed: -She first saw Resident #3 on 6/3/16. -She ordered daily BP checks, as she had no baseline for Resident #3, otherwise BP checks would have been less frequent. -She expected staff to obtain BP checks for residents as ordered. -She was not aware of Resident #3 passing out. Interview on 8/8/16 at 11:00AM with Staff J, MA,, revealed: -If a resident had an order for a daily BP check, MAs were expected to obtain them as ordered. -A time was assigned to daily BP checks and, just like a medication that was due, the electronic MAR would signal to the MA that a BP check was due. -The electronic MAR would just show tasks and orders for a given day and not for a longer period of time. -She did not check for trends in the computer beyond the given day at hand as she assumed someone else would do that. -She was familiar with Resident #3 and that she had a "panic attack" one time during her admission (she could not recall the date), but her BP check during that event was "normal." -She was not aware that Resident #3 had any complaints of lightheadedness or dizziness. Interview on 8/8/16 at 2:00PM with the Director revealed: -She was not aware Resident #3 did not get daily BP checks as ordered. -She expected the MAs to complete BP checks as ordered for individual residents.	D 276		

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D 338	Continued From page 14	D 338		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Type B Violation Based on interview and record review, the facility failed to treat residents with respect, dignity and full recognition of his or her individuality related to residents not allowed to make their own decisions concerning when to watch TV and to go smoke and the right to be free of verbal abuse from staff [Staff I]. The findings are: A. Review of Staff I's personnel file revealed: -A hire date of 7/12/16. -She was hired as a Medication Aide. -Her work hours were from 6:00 pm till 6:00 am. Attempted telephone interview with Staff I on 8/5/16 at 3:50 pm, 8/6/16 at 2:30 pm, and 8/7/16 at 10:00 am was unsuccessful. A confidential Interview with a resident revealed: -Every night Staff I told residents she was the "boss." -Staff I would sleep on the couch in the living room on night shifts and "it's a common occurrence." -She had not reported her concerns to anyone as "it won't do any good." -All the other staff were respectful.	D 338		

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D 338	Continued From page 15 A confidential interview with another resident revealed: -Staff I would boss residents around and told them to get in off the smoking porch between 10:00PM and 10:30PM. -Residents were supposed to be allowed to go out on the smoking porch at any time. -Staff I told residents to be in their bedrooms between 10:00PM and 11:00PM and would not let him go into the living room to watch television. -Staff I made them cry and feel sad. A confidential interview with a separate resident revealed: -Residents were told to be in their bedrooms by 9:30PM but she knew they were allowed to stay up to 12:00PM. -No other staff told residents they had to be in their bedrooms by 9:30PM. -Staff I was like a "sergeant." -Staff I made them feel like a "kid" and "stupid." -They had told the Director "the other day" that Staff I was sleeping on the couch in the living room. Interview with the Director on 8/8/2016 at 11:44 pm revealed: -She had received reports of Staff I telling residents to come inside from the smoking porch before the cut off time of 10:00pm. -Staff I told the residents to come in at 9:00pm or 9:30pm from the smoking porch. -The house rule had been that residents be out of the living room around 12:00 midnight in order for staff to clean the common areas of the facility, and then could return. -She had received no reports of residents being "chased" out of the living room at 9:00PM or 9:30PM.	D 338		

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D 338	Continued From page 16 -She had observed Staff I interacting with residents and she had to speak to Staff I "a time or two" as Staff I was getting residents inside off the smoking porch at 9:00PM or 9:30PM instead of 10:00PM. -She had told Staff I to watch what she was saying and how she was saying it to residents so it would not be construed as being intimidating. Interview with the Administrator on 8/8/2016 at 12:00pm revealed: -He was under the impression that the residents could stay in the living room and/or smoking porch as long as they were not disruptive. -He had not been aware the residents were being told to return to their rooms at a set time by staff. B. A confidential interview with a Personal Care Aide (PCA) revealed: -Staff I would get aggravated during a med pass if the residents came up to her and ask for their meds out of turn. -Staff I had been hateful to some residents, she got along better with the male residents than the female residents. -Staff I had been respectful in her interactions with residents about 50% of the time. -The PCA felt that Staff I's tone of voice had been too harsh. -Staff I had raised her voice with residents and she would then get is upset with the residents. -Staff I, sometimes used profanity toward the residents. A confidential Interview with a separate resident revealed: -Staff I, Medication Aide (MA) is a "[expletive]" and "gets hateful," telling residents they had to go to bed at 9:30PM. -Staff I would yell and scream at them which	D 338		

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D 338	Continued From page 17 made them feel angry and mad. A confidential interview with another resident revealed: -One worker was "hateful" and "I think it's [Staff I]." -Staff I made him cry and feel sad. A confidential interview with a separate resident revealed: -Staff I worked nights and was "very hateful." -Staff I had yelled and cussed at them. -Staff I was like a "sergeant." -Staff I made them feel like a "kid" and "stupid." Confidential interview with a different resident revealed: -They described a third shift staff person (no name could be remembered) who was "really terrible" and told residents she was "running the show." Interview with the Director on 8/8/2016 at 11:44 pm revealed: -She stated that none of the residents had reported to her that Staff I had yelled at them. -She spoke with Staff I about being careful what she said to the residents and how she said it. -Staff I was respectful towards the Director. -Director recalled speaking with the Adult Home Specialist on July 22, 2016 about a resident concern regarding Staff I yelling and cursing. -She "could not recall" any resident reporting that Staff I was yelling or cursing. -She had given Staff I a verbal warning about her tone of voice with residents, but had not issued a written warning. -She had told Staff I to watch what she was saying and how she was saying it to residents so it would not be construed as being intimidating.	D 338		

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D 338	Continued From page 18 Interview with the Administrator on 8/8/2016 at 12:00pm revealed he was not aware of Staff I's being loud and disrespectful with residents. _____ The plan of Protection provided by the facility on 8/8/16 revealed the Facility Director will: -Schedule the Ombudsman to do a residents rights class with all the staff. -The staff person involved in the violation was terminated. -The Director will check daily that the resident's rights are being maintained. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 22, 2016.	D 338		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to treat residents with respect, dignity and full recognition of his or her individuality and the right to make the decision to remain in the dayroom and watch television as long as they wanted to and to smoke when they wanted to. The findings are:	D911		

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D911	Continued From page 19 Based on interview and record review, the facility failed to treat residents with respect, dignity and full recognition of his or her individuality related to residents not allowed to make their own decisions concerning when to watch TV and to go smoke and the right to be free of verbal abuse from staff [Staff I]. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D911		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations in the areas of, failure to ensure residents' were free from verbal abuse related to [Staff I] cursing and yelling at residents. The findings are: Based on interview and record review, the facility failed to treat residents with respect, dignity and full recognition of his or her individuality related to residents not allowed to make their own decisions concerning when to watch TV and to go smoke and the right to be free of verbal abuse from staff [Staff I]. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D914		

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D914	Continued From page 20 Based on interview and record review, the facility failed to treat residents with respect, dignity and full recognition of his or her individuality and the right to be free of verbal abuse from staff [Staff I]. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if	D935		

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D935	Continued From page 21 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: Based on review of records the facility failed to assure 3 of 3 medication aides (Staff B, C, and I) who had administered medications, were clinically validated to administer medications. The findings are: A. Review of Staff B's personnel file revealed: -A hire date of 6/1/16. -She was hired as a Personal Care Aide / Medication Aide. -She passed the written medication exam in	D935		

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D935	Continued From page 22 2009. -No documentation of a completed clinical medication administration validation. Attempted telephone interview with Staff B on 8/4/16 at 11:15 am was unsuccessful. Review of the sampled residents' July 2016, and August 2016 medication administration records did reveal that Staff B administered medications to the residents in the facility. B. Review of Staff C's personnel file revealed: -A hire date of 3/31/16. -She was hired as a Medication Aide. -She passed the written medication exam in 2008. -No documentation of a completed clinical medication administation validation. Attempted telephone interview with Staff C on 8/5/16 at 12:15 pm was unsuccessful. Review of the sampled residents' July 2016, and August 2016 medication administration records did reveal that Staff C administered medications to the residents in the facility. C. Review of Staff I's personnel file revealed: -A hire date of 7/12/16. -She was hired as a Medication Aide. -She had not taken a medication exam. -No documentation of a completed clinical medication administration validation. Attempted telephone interviews with Staff I on 8/5/16 at 3:50 pm, 8/6/16 at 2:30 pm, and 8/7/16 at 10:00 am was unsuccessful.	D935		

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D935	Continued From page 23 Review of the sampled residents' July 2016, and August 2016 medication administration records did reveal that Staff I administered medications to the residents in the facility. Interview with Resident # 2 on 8/4/2016 9:45am revealed, Staff I had administered her medications in the mornings. Interview with the Facility Director on 8/8/16 at 12:30 pm revealed: -She had attempted to schedule the staff for the clinical medication administration validation. -Every time she tried to schedule the validation the pharmacy could not complete it. Interview with the facility pharmacy contact person on 8/5/16 at 9:40 am revealed: -They always went to the facility to provide competency evaluation for Personal Care Aides when contacted. -They were not aware of the facility contacting them about the need for competency evaluations. -He had been at the facility monthly for several months and no one had ever notified him of the need for the competency evaluations. Interview with the Administrator on 8/8/16 at 12:00 pm revealed: -The Facility Director was supposed to make sure all the staffing qualifications were in place. -He did expect for the Medication Aides to have the Clinical Medication administation validation completed. Attempted interview on 8/8/16 at 11:30 pm with the LHPS Nurse was unsuccessful.	D935		
D992	G.S.§ 131D-45 (a) Examination and screening	D992		

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D992	Continued From page 24 G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by:	D992		

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D992	Continued From page 25 Based on interviews and record reviews, the facility failed to assure an examination and screening for the presence of controlled substances was preformed for 1 of 9 sampled staff (Staff I) hired after 10/1/13 before the employee began working at the facility. The findings are: Review of Staff I's personnel file revealed: -She was hired on 7/12/16 as a Medication Aide. -There was no documentaion a controlled substance screening had been performed before Staff I began working at the facility. Attempted interview with Staff I on 8/5/16 at 3:50 pm, 8/6/16 at 2:30 pm, and 8/7/16 at 10:00 am was unsuccessful. Interveiw with the Facility Director on 8/5/16 at 11:45 am revealed: -When an employee starts the facility she fills out the paperwork and sends the staff person to the local health department for drug testing. -She did not have a system in place to assure that the staff actually go to the health department for drug testing. Interveiw on 8/8/16 at 12:15 pm with the Administrator revealed: -He thought the Facility Director had all the drug screens for staff completed. -His expectation was that all staff were drug tested before they started work. Interview with the Facility Director on 8/8/16 at 1:30 pm revealed: -She had checked with [contact name at health department] at the local health department and Staff I had never came in nor been tested.	D992		

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