PRINTED: 06/12/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED C B. WNG HAL011002 05/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD **BECKY REST HOME 1** FLETCHER, NC 28732 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 000 Initial Comments D 000 The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual survey on May 30-31, 2018. D 164 10A NCAC 13F .0505 Training On Care Of D 164 Diabetic Resident 6/1/18 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: (g) universal precautions: (h) appropriate administration times; and

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(i) sliding scale insulin administration.

This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 3 of 3 medication aides sampled (Staff A, B and C) received training by a licensed health professional on the care of

TITLE

(X6) DATE

STATE FORM

If continuation sheet 1 of 12

* See page 12 for administrators signature
Reviewed and accepted 7/13/18

6CNJ11

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED C HAL011002 B. WING 05/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD **BECKY REST HOME 1** FLETCHER, NC 28732 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 164 Continued From page 1 D 164 diabetic residents prior to administering insulin. The findings are: Interview with the Resident Care Coordinator (RCC) on 05/31/18 at 8:30am revealed there was one insulin dependent resident in the facility. 1. Review of Staff A's personnel file revealed: -Staff A was hired on 03/12/18 as a Medication Aide (MA). -There was documentation Staff A completed a medication clinical skills validation on 03/13/18. -There was documentation Staff A successfully passed the medication administration exam on 11/04/08. -There was no documentation of diabetic care training on file. -There was documentation of employment at another assisted living facility as a MA from 10/2014 through 08/20/17. Review of the May 2018 Medication Administration Records (MAR) revealed Staff A had administered medications to the residents on a routine basis. Observation of Staff A on 05/30/18 at 2:15pm revealed she was administering medications to the residents. Interview with Staff A on 05/30/18 at 4:00pm revealed: -She "administered medications to the residents" at the facility. -She was the MA today (05/30/18). -She had "previously worked as a MA at another assisted living facility for 3 years". -She had been "administering medications since 2006".

Division of Health Service Regulation

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C HAL011002 B. WNG 05/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD **BECKY REST HOME 1** FLETCHER, NC 28732 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 164 Continued From page 2 D 164 -She was in the process of obtaining copies of her personnel record, including trainings, from her previous employer. -She had completed diabetic care training at a previous place of employment. Refer to the interview with the Business Office Manager (BOM) on 05/31/18 at 9:40am. Refer to the interview with the RCC on 05/31/18 at 8:31am. Refer to the interview with the Registered Nurse (RN) on 05/31/18 at 12:30pm. Refer to the interview with the Administrator on 05/31/18 at 1:17pm. 2. Review of Staff B's personnel file revealed: -Staff B was hired on 04/17/18 as a MA. -There was documentation Staff A completed a medication clinical skills validation on 05/14/18. -There was documentation Staff A successfully passed the medication administration exam on 06/06/17. -There was no documentation of diabetic care training on file. -There was documentation of employment at another assisted living facility as a MA, dates of employment not documented. Review of the May 2018 MAR revealed Staff B had administered medications to the residents on a routine basis. Telephone interview with Staff B on 05/31/18 at 1:12pm was unsuccessful. Refer to the interview with the BOM on 05/31/18

Division of Health Service Regulation

at 9:40am.

6CNJ11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011002			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED C	
		B. WNG			05/31/2018		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE			
BECKY R	EST HOME 1	316 LOV	VER BUSH CREEK	ROAD			
		The state of the s	IER, NC 28732				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) (X5) COMPLETE DATE				
D 164	Continued From pag	ge 3	D 164				
	Refer to the interview at 8:31am.	w with the RCC on 05/31/18					
	Refer to the interview 12:30pm.	w with the RN on 05/31/18 at					
	Refer to the interview 05/31/18 at 1:17pm.	w with the Administrator on					
	-Staff C was hired or -There was documed medication clinical si -There was documed	s personnel file revealed: n 10/18/17 as a MA. ntation Staff C completed a kills validation on 10/18/17. ntation Staff C successfully on administration exam on					
	06/06/17There was no docur on file.	mentation of diabetic training					
	-There was no docur	mentation of employment					
	facility.	eginning work as a MA at the nation of employment at two facilities, dates of umented.					
	Review of the May M administered medica routine basis.	MAR revealed Staff C had tions to the residents on a					
THE COLUMN	Interview with a residence revealed Staff C admirations (8:00pm	dent on 05/31/18 at 11:45am ninistered his nighttime n).					
	Telephone interview contracted pharmacy was unsuccessful.	with the RN from the facility's on 05/31/18 at 11:50am					
	Telephone interview of 1:11pm was unsucce	with Staff C on 05/31/18 at					

Division of Health Service Regulation

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL011002 B. WING 05/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD **BECKY REST HOME 1** FLETCHER, NC 28732 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 164 Continued From page 4 D 164 Refer to the interview with the BOM on 05/31/18 at 9:40am. Refer to the interview with the RCC on 05/31/18 at 8:31am. Refer to the interview with the RN on 05/31/18 at 12:30pm. Refer to the interview with the Administrator on 05/31/18 at 1:17pm. Interview with the BOM on 05/31/18 at 9:40am -Staff trainings were completed by the RN. -The RN had been employed at the facility for about 11/2 months. -Prior to hiring the RN, the training was completed by a RN contracted from the facility's contracted pharmacy. -Prior to hiring the RN, the RCC completed this -She did not know reason there was no diabetic care training for Staff A, B or C. -Prior to hiring the RN, the RCC was responsible to "keep up with" the training needs of the staff. Interview with the RCC on 05/31/18 at 8:31am revealed: -Staff trainings were completed by the RN. -The RN had been employed at the facility for about 11/2 months. -Prior to hiring the RN, the training was completed by a RN contracted from the facility's contracted pharmacy. -She did not know the reasons the diabetic care training had not been completed.

Division of Health Service Regulation

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL011002 B. WNG 05/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD **BECKY REST HOME 1** FLETCHER, NC 28732 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 164 Continued From page 5 D 164 Interview with the RN on 05/31/18 at 12:30pm revealed: -She had been employed at the facility for about 11/2 months. -She was responsible to complete the staff trainings. -She was not aware the diabetic care training had had not been completed on Staff A, B or C. -She had not received any complaints from the diabetic resident. -She has observed Staff A and B administer insulin to the resident and had no concerns. Interview with the Administrator on 05/31/18 at 1:17pm. -Prior to hiring the RN, the BOM and RCC were responsible for auditing and personnel records to assure all staff trainings were completed. -The facility had a "checklist" that was used to track staff record requirements. -"They may need to add to the checklist" based on the survey findings. -She thought the diabetic care training had been completed for Staff A, B and C by the RN from the contracted pharmacy. -She would assure the training was completed. D935 G.S.§ 131D-4.5B(b) ACH Medication Aides; D935 5/31/18 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

Division of Health Service Regulation

STATE FORM

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C HAL011002 B. WING 05/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD **BECKY REST HOME 1** FLETCHER, NC 28732 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRFFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D935 Continued From page 6 D935 an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 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 interviews, observation and record

Division of Health Service Regulation

reviews, the facility failed to assure 2 of 3 medication aides sampled (Staff A and Staff C)

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C B. WING HAL011002 05/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD **BECKY REST HOME 1** FLETCHER, NC 28732 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D935 Continued From page 7 D935 completed the 5, 10 or 15 hour medication training or had verification of previous employment before administering medication to residents. The findings are: 1. Review of Staff A's personnel file revealed: -Staff A was hired on 03/12/18 as a Medication Aide (MA). -There was documentation Staff A completed a medication clinical skills validation on 03/13/18. -There was documentation Staff A successfully passed the medication administration exam on 11/04/08. -There was no documentation of a 5, 10 or 15 hour medication training on file. -There was no documentation of employment verification prior to beginning work as a MA at the -There was documentation of employment at another assisted living facility as a MA from 10/2014 through 08/20/17. Review of the May 2018 Medication Administration Records (MAR) revealed Staff A had administered medications to the residents on a routine basis. Observation of Staff A on 05/30/18 at 2:15pm revealed she was administering medications to the residents. Interview with Staff A on 05/30/18 at 4:00pm revealed: -She "administered medications to the residents" at the facility. -She was the MA today (05/30/18). -She had been "administering medications since 2006."

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING HAL011002 05/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD **BECKY REST HOME 1** FLETCHER, NC 28732 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY D935 Continued From page 8 D935 -She was in the process of obtaining copies of her personnel record, including trainings, from her previous employer. -She had completed the 15 hour medication aide training at a previous place of employment. Refer to the interview with the Business Office Manager (BOM) on 05/31/18 at 9:40am. Refer to the interview with the Resident Care Coordinator (RCC) on 05/31/18 at 8:31am. Refer to the interview with the Registered Nurse (RN) on 05/31/18 at 12:30pm. Refer to the interview with the Administrator on 05/31/18 at 1:17pm. 2. Review of Staff C's personnel file revealed: -Staff C was hired on 10/18/17 as a MA. -There was documentation Staff C completed a medication clinical skills validation on 10/18/17. -There was documentation Staff C successfully passed the medication administration exam on 06/06/17. -There was no documentation of a 5, 10 or 15 hour medication training on file. -There was no documentation of employment verification prior to beginning work as a MA at the -There was documentation of employment at two other assisted living facilities, dates not documented. Review of the March 2018 and April 2018 MARs revealed Staff C had administered medications to the residents on a routine basis. Interview with a resident on 05/31/18 at 11:45am revealed Staff C administered his nighttime

Division of Health Service Regulation

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED C HAL011002 B. WING 05/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD BECKY REST HOME 1 FLETCHER, NC 28732 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D935 Continued From page 9 D935 medications (8:00pm). Telephone interview with the RN from the facility's contracted pharmacy on 05/31/18 at 11:50am was unsuccessful. Telephone interview with Staff C on 05/31/18 at 1:11pm was unsuccessful. Refer to the interview with the BOM on 05/31/18 at 9:40am. Refer to the interview with the RCC on 05/31/18 at 8:31am. Refer to the interview with the RN on 05/31/18 at 12:30pm. Refer to the interview with the Administrator on 05/31/18 at 1:17pm. Interview with the BOM on 05/31/18 at 9:40am -Staff trainings were completed by the RN. -The RN had been employed at the facility for about 11/2 months. -Prior to hiring the RN, the training was completed by a RN contracted from the facility's contracted pharmacy. -The RN would secure an employment verification form from an employee's previous employer. -Prior to hiring the RN, the RCC completed this task. -She did not know reason there was no employment verification for Staff A or Staff C. -She did not know reason there was no 5, 10 or 15 hour medication training for Staff A or Staff C. -Prior to hiring the RN, the RCC was responsible

Division of Health Service Regulation

6CNJ11

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL011002 B. WING 05/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD **BECKY REST HOME 1** FLETCHER, NC 28732 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D935 Continued From page 10 D935 to "keep up with" the training needs of the staff. Interview with the RCC on 05/31/18 at 8:31am revealed: -Staff trainings were completed by the RN. -The RN had been employed at the facility for about 11/2 months. -Prior to hiring the RN, the training was completed by a RN contracted from the facility's contracted pharmacy. -She did not know reason there was no employment verification for Staff A or Staff C. -"I have personally handed the employment verification form to an owner of Staff C's previous employer, twice, and they have not responded. The BOM and the administrator" have both called the facility and received no response. Interview with the RN on 05/31/18 at 12:30pm revealed: -She had been employed at the facility for about 11/2 months. -She was responsible to complete the staff trainings. -She would coordinate with the new employee securing an employment verification form from the new employee's previous employer. -She did not know reason there was no employment verification for Staff A because Staff A was hired around the same time she was hired. -She did not know reason there was no employment verification for Staff C because Staff C was hired before she started employment at the facility. -She was not aware medication training had to be completed if employment verification could not be obtained. Interview with the Administrator on 05/31/18 at 1:17pm.

Division of Health Service Regulation

6CNJ11

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C HAL011002 B. WING 05/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD **BECKY REST HOME 1** FLETCHER, NC 28732 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D935 Continued From page 11 D935 -Prior to hiring the RN, the BOM and RCC were responsible for auditing and personnel records to assure all staff trainings were completed. -The facility had a "checklist" that was used to track staff record requirements. -"They may need to add to the checklist" based on the survey findings. -She was not aware there was no employment verification form or medication aide training for Staff A, she "thought they had all of her paperwork". -She, the BOM and the RCC had tried on numerous occasions to obtain the employment verification form for Staff C. -Staff C's medication aide training had not been scheduled because Staff C had been on personal medical leave, it had been "a challenge" to schedule trainings with the RN from the contracted pharmacy because she only worked "part time" and now that they had hired a RN, she was in the process of scheduling the necessary trainings for the staff. -She thought the facility had received Staff A's employment verification form earlier today (05/31/18). -She would assure the verifications were obtained or the training completed.

Division of Health Service

STATE FORM

6CNJ11

If continuation sheet 12 of 12

Becky's Rest Home #1 Survey Completed 5/31/2018 Pg 1 DHSR Statement of Deficiencies/Planof Correction 10 NCAC 13F Training on Care of Diabetic Repidents D164 Kule not met as evidenced by: Based on Interview and records review the facility facled to assure 3083 medication sides received training by a licensed health professional on the care of disbetic residents prior to administering insulin Staff A: I here was no documentation of diabetic care training on File - Training done and documented for disbetic care and Infection Control (including Universal Precoutions) on June 7, 2018 Staff B: There was no documentation of diabetic care training on file - Iraining done and documented on diabetic care and infection control (Including Universal Precoutions) on June 7, 2018

Staff C: There was no documentation of diabetic training on File.

Training done and documented andiabetic care and Infection Control (Including Universal Precautions on June 7,2018

Staff C: There was no documentation of employment verification prior to beginning usede as a Medication Aide at the facility

- On Ioliolia (DOH) employee
received 5-hour medication administration
by toin Madema, R. Americare Pharmacy
10-hr training due after leo days was
not done due to employee being
out on medical leave. This employee
wo no longer on staff. In the future,
Medication Aideo will be supervised
or trained (5,10,15hr) if proper employmen
verification cannot be obtained upon
hire. We now have an RN on staff to
handle this training as it comes
up. We are no longer confined to
the schedule of a Pharmacy
contracted RN.

BID-4.5B(b) medication Aides Training and Competency D 935 Beginning October 1, 2013, an adout care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide deering the previous 24 months in an about care home or Successfully completed: #1-A 5-hr-fraining program developed by the Department that includes training and instruction in all of the following: a) Key principals of medication administration b) Infection Control and Safe injection Practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. #Z Clinical Skulls Checklist #3 Within 60 days of DOH individual must have completed 10-hr program training on Key Drincipals of medication, Infection Control and 52 Fe Injection Practices

Rule not met as evidenced by interviews, observation and record reviews. The Facility failed to assure Z of 3 medication sides sampled (Staff A and Staff C) completed 5, 10 or 15 hr medication training or had verification of previous employment before administering medication to residents

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Staff A: No documentation of 5,10 or 15 hr medication training on file. No documentation of employment ventication Drior to Deginning work as a medication Aide at the Facility (Documentation Received 5/31/18)

Staff C: There was no documentation of a 5.10, 15 hr medication training on file. There was no documentation of of employment reinfication prior to beginning work as a Medication Aida at the facility.

Reinun of Staff records Show 5-hr Medication Training was done on Iolialin (DOH) by ton Madems, PN Staff RN is in charge of Staff
Development and viril assure all
training is done prior to Medication
Ande being un supervised on the Med
Cart. She has all State training
available to her and has been
accredited to assign CEU's to this
training. She also does diabetic
training, universal precautions and
Infection Control as part of new staff
or centation