STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL090040	A. BUILDING: _____ B. WING _____	07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE AT WINGATE	111 MAYE STREET WINGATE, NC 28174

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on 06/27/18, 06/28/18 and 06/29/18 with an exit conference via telephone on 07/03/18.	C 000		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .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 Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure a referral appointment for 1 of 3 sampled residents (#1) who had an orthopedic physician follow up appointment for foot pain and swelling (#1). Review of Resident #1's current FL-2 dated 03/09/18 revealed diagnoses included congestive heart failure, vertigo, Meniere's disease, gastro-esophageal reflux disease, degenerative disk disease secondary to arthritis, history of hip fracture and coronary artery disease with a history of bypass surgery. Interview with Resident #1 on 06/28/18 at 3:24pm revealed: -She had seen a doctor for pain and swelling of her left foot, but she could not remember when that was. -The doctor had prescribed stockings for her to wear, but she did not like to wear them because	C 249		

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the stockings made her legs hurt.
-The pain and swelling was "not so bad" on 06/28/18.

Observation of Resident #1's lower legs and ankles on 06/28/18 at 3:24pm revealed there was visible swelling and redness to Resident #1's left ankle.

Telephone interview with Resident #1's physician's medical assistant on 06/29/18 at 11:22am revealed Resident #1 was referred to an orthopedic doctor for pain and swelling of her left leg in May 2018.

Review of Service Notes and physician's orders for Resident #1 revealed there was no documentation of an order for an orthopedic referral.

Telephone interview with the orthopedic physician's triage nurse on 06/29/18 at 1:48pm revealed:
-Resident #1 was seen by the orthopedic physician's assistant (PA) on 05/15/18 and was prescribed colchicine (a medication used to treat gout) to take for two weeks.
-Resident #1 was supposed to follow up with the PA in one week and was a no show for her appointment on 05/22/18.

Telephone interview with the Administrator on 07/03/18 at 9:31am revealed:
-She had just written Resident #1's follow up orthopedic appointment on the calendar, but she could not remember the date of the appointment.
-Resident #1's family member normally took the resident to her appointments and brought back any new orders and follow up appointment cards.
-Resident #1's family member scheduled all of

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C 249	Continued From page 2 Resident #1's appointments and then let the facility know when appointments were scheduled. -She thought the orthopedic appointment had been previously scheduled and that Resident #1 did not want to go. -Resident #1's appointment date and refusal to go were not documented in her record; the facility did not usually document appointments and/or refusals in the resident's record. Telephone interview with Resident #1's family member on 07/02/18 at 12:21pm revealed: -She had taken Resident #1 to the orthopedic doctor in May 2018 for a swollen left foot and difficulty walking. -An x-ray was done to rule a fracture verses gout, but the orthopedic doctor was unable to determine either way because there was too much swelling. -Resident #1 had gone to the emergency department (ED) "in the mean time" for a urinary tract infection and the ED doctor did not think the resident's left foot swelling and pain were due to gout. -She had discharge instructions from the ED, but she could not remember if she had given them to the facility staff or not. Upon request on 07/02/18, there was no record of ED discharge instructions dated between 05/15/18 and 05/22/18 for Resident #1 available for review. Review of Service Notes and physician's orders for Resident #1 revealed there was no documentation of contact with Resident #1's physician or the orthopedic PA related to discontinuing follow up care with the orthopedic PA.	C 249		

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C 264	Continued From page 3	C 264		
C 264	10A NCAC 13G .0904(c)(1) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service (c) Menus in Family Care Homes: (1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the Daily Food Requirements in Paragraph (d) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the menu used for residents meals included serving quantities for each meal according to recommended daily food requirements. The findings are: Review of the facility's undated Meal Plan revealed: -Each day listed menu items including drinks for breakfast, lunch and dinner but did not list the amount to be served for each item. -Breakfast menu examples included for Wednesday: pancakes, bacon, milk, juice and coffee; Thursday: Danish or pastry with sausage or bacon, milk, juice and coffee; and Friday: breakfast bowl, fruit, milk, juice and coffee. -Lunch menu examples included: for Wednesday: pasta, garlic bread, side salad, milk tea and water; Thursday: tuna pasta with veggies, bread and butter, tea and water; and Friday: pizza, sweet potato with brown sugar and cinnamon, tea and water. -Dinner menu examples included: for Wednesday: scalloped (did not indicate what was scalloped), ham with cheese, sour cream, butter	C 264		

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C 264	Continued From page 4	C 264		

and tea; Thursday: chili, cornbread, applesauce, tea and water; and Friday: peanut butter and jelly sandwich, mandarin orange slices, tea, water and milk.

Confidential interview with a family member revealed:
-Sometimes the resident(s) did not get enough to eat.
-Family members usually brought snacks in to supplement food for the resident(s).

Observations of the lunch meal on 06/28/18 revealed:
-Residents were served a cereal bowl which had approximately one half cup of cooked mixed vegetables (carrots, corn and green beans) and approximately two thirds of a cup of mayonnaise based pasta with tuna.
-Both the vegetables and pasta salad were in the same bowl which together made the bowl approximately half full.
-Residents were served a dinner roll, water, milk and ice cream.

Observations of the dinner meal on 06/28/18 revealed:
-Residents were served a cereal bowl which had iceberg lettuce, diced tomato pieces, scant amount of purple cabbage, a sprinkle of shredded cheese and approximately one to two slices of ham and turkey lunch meat cut up into squares with salad dressing.
-One resident requested and was given round crackers with the salad.
-Residents were served water and milk with the salad.

Interview with a personal care aide (PCA) on 06/29/18 at 2:59pm revealed:

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C 264	Continued From page 5 -She cooked meals, served the food and assisted residents with eating as needed as part of her job duties. -She prepared meals based on the menu posted in the kitchen at the facility. -She "just eye balled" how much food to put on the plate. Interview with the Administrator on 06/29/18 at 11:45am revealed: -She had purchased menus from a company that did list the serving quantity on the menu. -She had made a list of what the residents liked the most from the purchased menus and then made her own menu. -She and the staff went by the menu posted in the kitchen at the facility which was the one she had made. -She did not know the serving quantity recommendations for protein such as meat or for bread and grains. -She did not know the serving quantity needed to be listed on the menu posted for staff in the kitchen at the facility. -She usually made homemade meals for the residents and "went out of (her) way to make sure (residents) eat".	C 264		
C 272	10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.	C 272		

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C 272	Continued From page 6 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were offered snacks between each meal three times daily. The findings are: Observations on 06/28/18 from 9:35am until 12:23pm revealed there was no snack served or offered to the residents. Observations on 06/29/18 from 9:50am until 12:15pm revealed there was no snack served or offered to the residents. Observations on 06/29/18 from 12:30pm until 5:15pm revealed there was no snack served or offered to the residents. Review of the facility's undated Meal Plan posted in the kitchen at the facility revealed there were no snacks listed on the meal plan or menu. Confidential interview with a family member revealed: -Sometimes the resident(s) did not get enough to eat. -Family members usually brought snacks in to supplement food for the resident(s). Interview with a personal care aide (PCA) on 06/29/18 at 2:59pm revealed she asked residents every two to three hours if they wanted a snack or she may ask residents if they wanted whatever she might have had available for a snack. Interview with the Administrator on 06/29/18 at 12:11pm revealed:	C 272		

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C 272	Continued From page 7 -Residents were offered snacks throughout the day; there was no set snack times, but sometime between breakfast and lunch and sometime in the afternoon. -There were two residents that also kept snacks in their rooms; the residents' family members brought in a lot of their snacks.	C 272		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 sampled residents (#2) received nectar thickened liquids as ordered by the physician. Review of Resident #2's current FL-2 dated 06/22/18 revealed: -Diagnoses included altered mental status and hypoxia -There was an order for a mechanically altered diet with nectar thick liquids. Review of a hospital discharge summary dated 06/22/18 for Resident #2 revealed Resident #2 was admitted to the hospital on 06/19/18 for aspiration pneumonia and dehydration, and was discharged 06/22/18. Upon request on 06/28/18 and 06/29/18, there was no diet list available for review.	C 284		

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C 284	Continued From page 8 Observation during the lunch meal on 06/28/18 revealed Resident #2 was served milk thickened to the consistency of a milk shake which was fed to the resident by the personal care aide (PCA) by spoonfuls. Observation during the dinner meal on 06/28/18 revealed Resident #2 was served milk thickened to a thin nectar consistency. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable due to confusion. Review of Resident #2's care plan dated 05/31/18 revealed: -Resident #2 was confused and disoriented. -Resident #2 was able to feed himself and was on a regular diet. -Resident #2 required two persons for transfer assistance and was totally dependent on staff for toileting, bathing and dressing. Observation of the container of thickener stored on the facility's kitchen counter revealed: -There was an instruction chart on how much thickener to add to four ounces of water, apple juice orange juice, cranberry juice, coffee, tea, milk and nutritional supplements to make nectar, honey or pudding consistency. Interview with the PCA on 06/29/18 at 4:52pm revealed: -To thicken Resident #2's drinks to nectar consistency, she always started with two scoops and stirred until the drink was thick enough. -If the drink for Resident #2 was not thick enough after the two scoops, she would add a third scoop.	C 284		

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C 284	Continued From page 9 -All of Resident #2's drinks had to be "thicker than water, but not too thick or else he'll choke". -Resident #2's drinks were supposed to be nectar thick and she had put "a little too much" thickener in his milk at lunch on 06/28/18. -She had not been trained on how to mix nectar thick liquids for Resident #2, but had taught herself. According to the instructions on the container of thickener, four and one half to five teaspoons should have been added to four ounces of milk, to make the milk a nectar thick consistency. Interview with the Administrator on 06/29/18 at 5:02pm revealed: -Resident #2 was supposed to have nectar thick liquids. -She went over how to prepare nectar thick liquids for Resident #2 with all of the staff. -The facility had been using a different brand of thickener to prepare drinks for Resident #2 which had different directions for nectar thick liquids. -The change in brands may have caused a problem with preparing nectar thick drinks for Resident #2.	C 284		
C 316	10A NCAC 13G .1002(b) Medication Orders 10A NCAC 13G .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility. This Rule is not met as evidenced by: Based on observations, interviews and records reviews, the facility failed to assure orders for medications were maintained in the residents' records for 1 of 3 sampled residents (#1) where	C 316		

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C 316	Continued From page 10	C 316		

there was no order to discontinue colchicine (a gout medication).

The findings are:

Review of Resident #1's current FL-2 dated 03/09/18 revealed diagnoses included congestive heart failure, vertigo, Meniere's disease, gastro-esophageal reflux disease, degenerative disk disease secondary to arthritis, history of hip fracture and coronary artery disease with a history of bypass surgery.

Review of a prescription order dated 05/14/18 for Resident #1 revealed an order for colchicine 0.6mg twice daily. (Colchicine is used to treat gout)

Review of Resident #1's May and June 2018 MAR revealed there was no entry for colchicine 0.6mg twice daily.

Interview with Resident #1 on 06/28/18 at 3:24pm revealed:
-She had seen a doctor for pain and swelling of her left foot, but she could not remember when that was.
-The doctor had prescribed stocking for her to wear, but she did not like to wear them because the stockings made her legs hurt.
-The pain and swelling was "not so bad" on 06/28/18.

Observation of Resident #1's lower legs and ankles on 06/28/18 revealed there was visible swelling and redness to Resident #1's left ankle.

Telephone interview with Resident #1's family member on 07/02/18 at 12:21pm revealed:
-She had taken Resident #1 to the orthopedic

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C 316	Continued From page 11	C 316		

doctor in May 2018 for a swollen left foot and difficulty walking.
-An x-ray was done to rule a fracture verses gout, but the orthopedic doctor was unable to determine either way because there was too much swelling.
-Resident #1 had not urinated the morning she went to the ED and the resident's physician told the family member colchicine could cause renal failure so the family and Resident #1's physician decided to stop the colchicine.
-She had discharge instructions from the ED, but she could not remember if she had given them to the facility staff or not.

Upon request on 07/02/18, there was no record of ED discharge instructions dated between 05/15/18 and 05/22/18 for Resident #1 available for review.

Interview with the Administrator on 06/28/18 at intervals between 3:40pm and 3:54pm revealed:
-The colchicine was started and discontinued the same day (05/14/18).
-Resident #1's family member brought any new orders back from doctor's appointments or the family member would take new orders directly to the pharmacy.
-If the family member took the order directly to the pharmacy, then the pharmacy would send a copy of the order to the facility when the medication was filled.
-Once the facility received a new order from the family member or the pharmacy, the Administrator or a medication aide would document the order on the MAR.

Telephone interview with the pharmacist on 06/28/18 at 10:14am revealed:
-The colchicine for Resident #1 was discontinued

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the same day (05/14/18).
-The facility contacted Resident #1's physician and got the medication discontinued.
-There was no written order to discontinue the colchicine for Resident #1.
-Usually the physician would call the pharmacy and say to discontinue a medication or the facility would fax any written orders to discontinue a medication.

Telephone interview with Resident #1's physician's medical assistant on 06/29/18 at 11:22am revealed:
-Resident #1's physician had not ordered nor discontinued colchicine.
-Resident #1 was referred to an orthopedic doctor for pain and swelling of her leg in May 2018.
-It was the orthopedic doctor who had prescribed colchicine for Resident #1.

Telephone interview with the orthopedic physician's triage nurse on 06/29/18 at 1:48pm revealed:
-Resident #1 was seen by the orthopedic physician's assistant (PA) on 05/15/18 and was prescribed colchicine to take for two weeks.
-Resident #1 was supposed to follow up with the PA in one week and was a no show for her appointment on 05/22/18.
-The PA did not discontinue the colchicine for Resident #1.

Telephone interview with the Administrator on 07/03/18 at 9:31am revealed:
-Resident #1's family member normally took the resident to her appointments and brought back any new orders.
-She was not aware Resident #1 was to take the colchicine for two weeks and follow up with the orthopedic PA.

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C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure a pain medication (tramadol) was administered as ordered by the physician for 1 of 3 sampled residents (#1). Review of Resident #1's current FL-2 dated 03/09/18 revealed: -Diagnoses included congestive heart failure, vertigo, Meniere's disease, gastro-esophageal reflux disease, degenerative disk disease secondary to arthritis, history of hip fracture and coronary artery disease with a history of bypass surgery. -There was an order for Tramadol 50mg three times daily. Review of Resident #1's April 2018 medication administration record (MAR) revealed: -There was an entry for tramadol 50mg three times daily, scheduled for 8:00am, 4:00pm and 8:00pm. -Staff documented administering 04/01/18 through 04/30/18 except at 4:00pm and 8:00pm on 04/05/18 and at 8:00pm on 04/10/18.	C 330		

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	FCL090040	A. BUILDING: _____ B. WING _____	07/03/2018

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C 330	Continued From page 14 Review of the tramadol controlled substance count sheets dated 04/25/18 through 05/04/18 and 05/04/18 through 05/17/18 for Resident #1 revealed: -On 04/28/18, the 1st shift medication aide (MA) documented administering the 8:00am and 4:00pm doses of tramadol with a remaining count of 22 tablets after the 4:00pm dose. -On 04/28/18, the 2nd shift MA documented "the 4:00pm dose of Tramadol was given at 9:00pm". -On 04/28/18, the 2nd shift MA documented the 9:00pm dose of tramadol was administered and the remaining count was 22 tablets. -Tramadol 50mg one table was documented as administered three times daily from 04/29/18 through 05/06/18 at 8:00am with no discrepancy in the count to zero tablets remaining. Based on review of Resident #1's April 2018 MAR and tramadol controlled substance count sheet dated 04/25/18 through 05/04/18, Resident #1 received tramadol 50mg twice on 04/28/18 instead of three times as ordered by the physician. Interview with the 1st shift MA on 06/28/18 at 12:17pm revealed: -She did not know what the entry by the 2nd shift MA for Resident #1's tramadol on 04/28/18 for 4:00pm meant because it was not her handwriting. -She left at 3:30pm that day (04/28/18). Observation on 06/28/18 at 12:17pm revealed the interview with the 1st shift MA was interrupted by the Administrator. Interview with the Administrator on 06/28/18 at 12:18pm revealed: -The 2nd shift MA meant to document that the	C 330		

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C 330	Continued From page 15 8:00pm tramadol was given at 9:00pm. -The 2nd shift MA no longer worked at the facility. Telephone interview with the former MA on 06/28/18 at 10:00am revealed: -She would have to see the entry on 04/281/18 on the tramadol controlled substance count sheet for Resident #1 in order to say why she wrote the comment. -She could not remember that specific incident, but she often came in to work for 2nd shift at 3:00pm, and 4:00pm medications would have already been given or the medications were left lying around. Review of Resident #1's May 2018 MAR revealed: -There was an entry for tramadol 50mg three times daily, scheduled for 8:00am, 4:00pm and 8:00pm. -Staff documented administering 05/01/18 through 05/31/18 except on 05/06/18 at 4:00pm through 05/08/18 at 8:00am, 05/09/18 at 8:00am and 05/22/18 and 05/24/18 at 4:00pm. -Under the section for medications not administered, staff documented tramadol was not available/needed a refill from 05/06/18 at 4:00pm through 05/08/18 at 8:00pm and that Resident #1 refused doses on 05/20/18 at 4:00pm and 05/24/18 at 4:00pm. Review of the tramadol controlled substance count sheets dated 05/04/18 through 05/17/18, 05/17/18 through 05/27/18 and 05/27/18 through 06/05/18 for Resident #1 revealed: -Staff documented there were no doses of Tramadol administered to Resident #1 after 05/06/18 at 8:00am until 05/09/18 at 4:00pm. -Staff documented administering the 8:00am and 8:00pm dose of tramadol on 05/10/18.	C 330		

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C 330	Continued From page 16 -There was no documentation the 4:00pm dose of tramadol was administered to Resident #1 on 05/10/18. -Staff documented the 4:00pm dose of tramadol was administered to Resident #1 on 04/20/18. -Staff documented administering the 8:00am and 8:00pm dose of tramadol on 05/22/18. -There was no documentation the 4:00pm dose of tramadol was administered to Resident #1 on 05/22/18. -There was no discrepancy in the documented count of remaining tablets. Based on review of Resident #1's May 2018 MAR and tramadol controlled substance count sheets dated 05/04/18 through 05/17/18 and 05/17/18 through 05/27/18, Resident #1 received tramadol 50mg twice on 05/10/18 and 05/22/18 instead of three times as ordered by the physician.	C 330		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication aide training and competency.	C 912		

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C 912	Continued From page 17 The findings are: Based on interviews and record reviews, the facility failed to assure 2 of 4 sampled medication aides (Staff B and Staff C) had been validated for clinical medication skills prior to administering medications to residents; and allowed 2 of 4 staff (Staff B and Staff C) to continue to pass medications for three months after failing the medication exam. [Refer to Tag 953 G.S.131D-4.5B(b) ACH Medication Aides; Training & Competency Evaluation Requirements (Type B Violation)]	C 912		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 2 of 4 medication aides	C 934		

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C 934	Continued From page 18 (Staff A and Staff D) completed the mandatory annual infection control training developed and approved by the Department. The findings are: 1. Review of Staff A's employee record revealed: -There was no hire date for Staff A. -There was an employment application signed by Staff A on 10/13/15. -There was a job description for Supervisor in Charge. -There was a medication aide (MA) verification form dated 5/29/17 and documentation Staff A passed the medication examination on 03/23/05. -There was documentation Staff A was validated for medication clinical skills on 05/27/18. -There was no documentation Staff A completed the annual mandatory infection control training developed and approved by the Department. Interview with the Administrator on 06/27/18 at 4:40pm revealed: -Staff A "probably" started working as a MA "a few weeks after her application date". -Staff A had completed trainings online; she would check and see if infection control was one of the trainings Staff A had completed. Interview with Staff A on 06/28/18 at 9:35am revealed: -She started working as a MA at the facility in October 2015. -She had not completed the annual mandatory infection control training developed and approved by the Department since October 2015. -She was working on completing the online mandatory infection control training developed and approved by the Department on the morning of 06/28/18.	C 934		

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C 934	Continued From page 19 Refer to interview with the Administrator on 06/27/18 at 4:40pm. 2. Review of Staff D's employee record revealed: -There was no hire date or job description. -Staff D completed the five hour training on 05/09/15 and the ten hour training on 07/07/15. -There was documentation Staff D was validated for medication clinical skill on 05/09/15. -There was documentation Staff D passes the medication examination on 03/23/15. -There was a certificate of completion for the mandatory infection control training dated 05/10/15. -There was no documentation Staff D completed the annual mandatory infection control training developed and approved by the Department since 05/10/15. Interview with Staff D on 06/28/18 at 9:59am and 10:45am revealed: -She was the Administrator since the facility opened in March 2015. -She administered medications to residents on a regular basis. -She had completed some continuing education courses online that covered some infection prevention. -She had not completed the annual mandatory infection control training developed and approved by the Department. Refer to interview with the Administrator on 06/27/18 at 4:40pm. Interview with the Administrator on 06/27/18 at 4:40pm revealed: -She was responsible for assuring staff	C 934		

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C 934	Continued From page 20 completed all required trainings. -She had a nurse from the pharmacy that came to the facility and completed medication aide related training and skills validation. -Staff would also complete some trainings online and the certificates were kept in the employee record.	C 934		
C935	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 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	C935		

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C935	Continued From page 21 training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure 2 of 4 sampled medication aides (Staff B and Staff C) had been validated for clinical medication skills prior to administering medications to residents; and allowed 2 of 4 staff (Staff B and Staff C) to continue to pass medications for three months after failing the medication exam. The findings are: 1. Review of Staff B's employee record revealed: -Staff B was hired on 10/24/17 as a Supervisor in Charge (SIC). -Staff B completed the 15 hour medication training on 10/29/17. -There was no documentation of medication clinical skills validation for Staff B. -There was documentation that Staff B failed the medication examination on 03/28/18. Interview with Staff B on 06/28/18 at 12:48pm revealed she worked at the facility for one year on	C935		

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C935	Continued From page 22 1st and 2nd shift and was responsible for helping residents get dressed, cooking meals and incontinence care. Interview with the Administrator on 06/27/18 at 4:40pm revealed Staff B was a personal care aide (PCA) and not a SIC. Interview with Staff B on 06/28/18 at 4:00pm revealed: -She had started administering medications to residents one to two months ago and stopped two weeks ago (06/14/18). -She had taken the 15 hour medication training, but had not been validated for medication clinical skills since she started working at the facility. Review of Resident #1's April, May and June 2018 medication administration records (MARs) revealed: -Staff B documented administering Resident #1's 8:00pm and 10:00pm medications on 04/04/18, 05/15/18, 05/24/18, 05/29/18, 05/30/18, 05/31/18, 06/02/18 through 06/05/18, 06/07/18, 06/11/18 and 06/12/18. Interview with Staff B on 06/28/18 at 4:32pm revealed: -A medication aide (MA) or the Administrator was present when she administered medications to residents. -Sometimes the Administrator was "in and out" of the facility, but would administer medications to residents when she was in the facility if Staff B was working by herself. -If she was working in the facility by herself, then she would administer medications to the residents because the residents "have to have their meds [sic]." -When the Administrator administered	C935		

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C935	Continued From page 23	C935		

medications to the residents, the Administrator signed the resident's MAR.

Refer to interview with the Administrator on 06/27/18 at 4:40pm.

Refer to attempted interview with the pharmacy nurse on 07/02/18 at 9:34am.

Refer to interview with the Administrator on 06/28/18 at 4:01pm.

2. Review of Staff C's employee record revealed:
-There was an employment application signed by Staff C on 10/09/17; there was no job description.
-Staff C completed the 15 hour medication training on 10/29/17.
-There was no documentation of medication clinical skills validation for Staff C.
-There was documentation that Staff C failed the medication examination on 03/28/18.

Interview with Staff C on 06/27/18 at 3:51pm revealed she was a personal care aide (PCA) and normally worked as the only staff on duty for 3rd shift.

Review of Resident #2's April, May and June 2018 medication administration records (MARs) revealed:
-Staff C documented administering Resident #2's 8:00am and 2:00pm medications on 04/04/18, 04/07/18, 04/08/18, 04/13/18, 04/21/18, 04/22/18, 04/26/18, 04/27/18, 05/05/18, 05/06/18, 05/19/18 and 05/20/18.
-Staff C documented administering Resident #2's 8:00pm and 10:00pm medications on 04/07/18, 04/08/18, 04/13/18, 04/21/18, 04/22/18, 05/05/18, 05/05/18, 05/09/18, 05/10/18, 05/19/18 and 05/20/18 .

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C935	Continued From page 24 Interview with Staff C on 06/29/18 at 9:50am revealed: -She had administered medications to residents, but not for a long period of time. -She had completed the 15 hour training (10/29/17), started administering medications and took the medication test in March 2018. -She stopped administering medications after she failed the medication test, but she could not remember the date. -She had never administered medications by herself, the Administrator was always in the facility when Staff C administered medications. -She documented administering medications on the resident's MAR whenever she administered medications. Refer to interview with the Administrator on 06/27/18 at 4:40pm. Refer to attempted interview with the pharmacy nurse on 07/02/18 at 9:34am. Refer to interview with the Administrator on 06/28/18 at 4:01pm. Interview with the Administrator on 06/27/18 at 4:40pm revealed: -She was responsible for assuring staff completed all required trainings. -She had a nurse from the pharmacy that came to the facility and completed medication aide related training and skills validation. -Whenever she hired new staff, she contacted the pharmacy nurse and made arrangements for trainings. -She was sure the pharmacy nurse had completed the medication clinical skills validation for all of the staff.	C935		

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C935	Continued From page 25 Attempted interview with the pharmacy nurse on 07/02/18 at 9:34am was unsuccessful. Interview with the Administrator on 06/28/18 at 4:01pm revealed: -She thought staff was able to administer medications "for a certain amount of time" before they had to take the test. -She thought once the staff had failed the test, the staff "had a certain block of time before (staff) had to take (the test) again". -She thought staff had time where she could watch them administer medications before the staff had to take the test again. -She, "not clear and at some point," made it so that she and Staff A administered all resident medications. -She was "not clear" on whether staff had to take the 15 hour medication training again and/or take the test again. -She "probably could have looked up" the regulation information on medication aide training and competency, but she did not. -She had confused the Licensed Health Professional Support skills validation with the medication clinical skills validation; there was no medication clinical skills validation for Staff B and Staff C. -She thought Staff B and Staff C could be watched while giving medications until they took the medication test again. -She was "pretty sure" she was in the facility "at least 12 to 13 hours each day. The failure of the facility failed to assure Staff B and Staff C were validated for medication clinical skills prior to administering and allowed Staff B and Staff C to continue to administering diuretic medications (furosemide and spironolactone),	C935		

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C935	Continued From page 26 psychiatric medications (risperidone, mirtazapine, escitalopram, sertraline, levetiracetam and Nuedexta) and pain medications (tramadol) for three months after failing the medication examination. The facility's failure to assure Staff B and Staff C were competent to administer medications placed residents at risk for medication errors and related adverse effects which was detrimental to the safety of all residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/28/18 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 17, 2018.	C935		