STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041881	A. BUILDING: _____ B. WING _____	12/17/2018

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RICHLAND PLACE	3823 LAWNDALE DRIVE GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on December 13, 14 and 17, 2018.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and B) were tested for tuberculosis (TB) upon hire. The findings are: 1. Review of Staff B, Medication Aide (MA)/Personal Care Aide's (PCA) personnel record revealed: -Staff B was hired on 08/07/18. -There was no documentation of a TB skin test. Interview on 12/18/18 at 2:15 pm with Staff B revealed: -She had worked at the facility since early August 2018. -She worked as a MA and a PCA.	D 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Chilley TITLE: Executive Director (X6) DATE: 2-8-2019

Received & Acknowledged
Darlene Kay Parr 2/13/19

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D 131	Continued From page 1 -She provided medication administration, showers, ambulation assistance, transfer assistance to residents as needed. -Staff B did have a TB skin test placed and read upon employment at the facility. -She had provided the facility with the documentation of the negative TB skin test, which should be in her personnel record. -She had not been told by staff at the facility she needed another TB skin test. Interview on 12/17/18 at 5:30 pm with the Business Office Manager (BOM) revealed: -Staff B did have a TB skin placed upon hire. -She did not know why it was not in Staff B's personnel record. Refer to interview with the facility Nurse. Refer to interview with the Executive Director (ED). 2. Review of Staff A personal care aide's (PCA) personnel record revealed: -Staff A was hired on 07/25/18. -There was documentation of a TB skin test read on 07/20/18 with negative results. -There was no additional documentation of another TB skin test. Interview on 12/17/18 at 6:30 pm with Staff A revealed: -She had worked at the facility as a PCA since July 2018. -She did have one TB skin test placed, which was negative. -She had been told by the Business Office Manager (BOM) she needed a second TB skin test. -Staff A had not gone to have the second skin test	D 131		

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D 131	Continued From page 2 performed, because she forgot about it. -She would have the second TB skin test performed as soon as she could. Interview on 12/17/18 at 5:30 pm with the BOM revealed: -She did not know Staff A had not had a second TB skin test performed, but she would schedule it as soon as possible. -She was responsible for scheduling the first TB skin test, but the facility Nurse was responsible for performing the second TB skin test. Refer to interview with the facility Nurse. Refer to interview with the Executive Director (ED). Interview on 12/14/18 at 5:45 pm with the facility nurse revealed: -She was new to the facility, she had begun her job in October 2018. -She did not know any employee needed TB skin tests, but she would perform the TB skin tests as soon as possible. Interview on 12/17/18 at 7:00 pm with the ED revealed: -The ED was responsible for the accuracy and completion of the required items in each employee record. -She was not aware staff personnel records did not contain TB skin tests results. The facility failed to ensure staff were free from active TB disease placed the residents at risk for potential exposure to TB. This failure was detrimental to the health, safety and welfare of all residents and constitutes a Type B Violation.	D 131		

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D 131	Continued From page 3 The facility provided a plan of protection in accordance with G. S. 131D-34 on 12/17/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2019.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff A personal care aide's (PCA) personnel record revealed: -Staff A was hired on 07/25/18. -Staff A completed nurse aide (NA) training. -There was no documentation of a HCPR check in Staff A's personnel record.	D 137		

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D 137	Continued From page 4 Interview on 12/17/18 at 5:30 pm with the Business Office Manager (BOM) revealed: -The HCPR check for Staff A had been completed on 12/17/18. -There was no other HCPR check for Staff A. -She was responsible for completing the HCPR check on every employee. -She had not completed a HCPR check on Staff A until today, because she wanted to wait until Staff A completed NA training. Interview on 12/17/18 at 6:30 pm with Staff A revealed: -She was hired in July 2018 as a personal care aide. -She completed NA training on 11/07/18. -She did not know if a HCPR check was completed when she was hired or not. Interview with the Executive Director (ED) on 12/17/18 at 7:00 pm revealed: -Each employee should have a completed HCPR with no substantiated findings in the personnel record. -The BOM was the employee who completed the HCPR check on new hires. -She did not know until today, that a HCPR had not been completed on Staff A upon hire. -The ED was responsible for ensuring each personnel record was complete and accurate. The facility failed to ensure staff had a HCPR check completed prior to hire. This failure resulted in the facility not knowing if staff had substantiated findings on the HCPR which was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G. S. 131D-34 on 12/17/18 for	D 137		

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D 137	Continued From page 5 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2019	D 137		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff B) was competency validated for Licensed Health Professional Support (LHPS) tasks. The findings are: Review of Staff B medication aide(MA)/personal care aide's (PCA) personnel record revealed: -Staff B was hired on 08/07/18. -There was no documentation a LHPS competency validation had been completed.	D 161		

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D 161	Continued From page 6 Interview on 12/18/18 at 2:15 pm with Staff B revealed: -She had worked at the facility since early August 2018. -She worked as a MA/PCA. -She provided medication administration, ambulation assistance, transfer assistance, fingerstick blood sugar (FSBS) checks and administered insulin to residents as needed. Interview on 12/17/18 at 5:30 pm with the Business Office Manager revealed: -Staff records did not contain completed LHPS competency validation, because "our company does not complete those". -The facility Nurse did not currently complete LHPS competency validation. Interview on 12/17/18 at 5:45 pm with the facility Nurse revealed: -She did not know staff needed the LHPS competency validations completed. -She was responsible for providing the LHPS competency validation to employees. -She would provide the required LHPS competency validation to all staff as soon as possible. Interview on 12/17/18 at 8:00 pm with the Executive Director (ED) revealed: -The facility Nurse did not presently complete the LHPS competency validation for employees, because "we didn't know that was required". -The facility would ensure each employee who needed LHPS competency validation would receive it as soon as possible. -The ED was responsible for the accuracy and completion of the required items in each employee record.	D 161		

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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; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 of 2 medication aides (Staff B) received training of the care of the diabetic resident prior to the administration of insulin to residents. The findings are: Review of Staff B medication aide (MA)/personal	D 164		

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D 164	Continued From page 8 care aide's (PCA) personnel record revealed: -Staff B was hired on 08/07/18 as a MA/PCA. -There was no documentation of training on the care of the diabetic resident. Review of the October 2018 Medication Administration Record (MAR) for an insulin dependent resident revealed Staff B perfomed eleven fingerstick blood sugars (FSBS) and administered insulin eight times. Review of the November 2018 MAR for the same insulin dependent resident revealed Staff B perfomed six FSBSs and administered insulin six times. Interview on 12/18/18 at 2:15 pm with Staff B revealed: -She had worked at the facility since early August 2018. -She worked as a MA/PCA. -She performed fingerstick blood sugar (FSBS) checks and administered insulin as needed. -She did not receive any training on the care of the diabetic resident at the facility. Interview on 12/17/18 at 5:30 pm with the Business Office Manager (BOM) revealed: -The facility did not provide training on the care of the diabetic resident. Interview with the facility Nurse on 12/17/18 at 5:45 pm revealed: -She did not know Staff B needed the diabetic care training. -She would provide the required diabetic care training to Staff B as soon as possible. Interview on 12/17/18 at 7:00 pm with the ED revealed:	D 164		

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D 164	Continued From page 9 -The facility did not presently offer the required diabetic care training to employees. -The facility would ensure each employee who needed the required training on the care of the diabetic resident would receive it as soon as possible. -The ED was responsible for the accuracy and completion of the required items in each employee record.	D 164		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure an appointment was scheduled for 1 of 3 sampled residents (Resident #1) regarding a referral to a cardiologist. The findings are: Review of Resident #1's current FL2 dated 04/05/18 revealed diagnoses included major neurocognitive disorder due to multiple etiologies with behavioral disturbances and hypertension. Review of Resident #1's physician encounter forms revealed:	D 273		

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D 273	Continued From page 10 -There was a hospital admission dated 07/25/18 with a hospital discharge dated 07/28/18. -Resident #1 was diagnosed with atrial fibrillation (a-fib) and ordered a medication to treat a-fib upon discharge on 07/28/18. Review of Resident #1's physician's order dated 08/21/18 revealed an order for a "cardiology referral; F/U (follow up). New Dx (diagnosis) AFIB RVR (rapid ventricular rate)". Review of Resident #1's record revealed there was no documentation of a visit to a cardiologist. Interview with the facility Nurse on 12/14/18 at 12:00 pm revealed: -The Resident Care Coordinator (RCC) was responsible to schedule residents' appointment. -She did not know Resident #1 had an order for a referral to a cardiologist dated 08/21/18. -She had not audited Resident #1's record, including auditing for health care referrals. Interview on 12/14/18 at 3:15 pm with the RCC revealed: -She was responsible to schedule residents' appointments. -She had a calendar used to track residents' scheduled appointments -She would arrange with the transportation driver when a resident had an appointment scheduled. -Routinely, physician orders for referrals or appointments were forwarded by medication aides to her, but it appeared the referral was faxed to the pharmacy and placed in the record (like a medication order) and did not make it to her office. -She had not scheduled Resident #1's cardiology appointment. -She must have overlooked the order for a	D 273		

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D 273	Continued From page 11 cardiology referral because she did not recognize the order. -There was not a system in place for auditing residents' records for health care referrals. Telephone interview on 12/14/18 at 3:40 pm with the Nurses Practitioner from Resident #1's primary care office revealed: -She ordered the cardiology referral on 08/21/18. -She saw Resident #1 routinely about every 3 months. -She did not know Resident #1's cardiology referral was not done. -There was no documentation available the referral had been done. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Telephone interview on 12/17/18 with Resident #1's guardian revealed: -She did not know Resident #1 had a cardiology referral ordered on 08/21/18, after a hospitalization. -Routinely, the facility would notify her for approval for all referrals for Resident #1. -She had not been contacted regarding Resident #1's order for a cardiology referral. Interview with the Executive Director (ED) on 12/17/18 at 4:10 pm revealed: -The RCC was responsible to schedule referral appointments and notify the provider and guardian in the event an appointment was not completed. -The RCC must have overlooked the order for Resident #1's cardiology appointment.	D 273		

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D 344	Continued From page 12	D 344		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 1 of 5 sampled residents (Resident #4) regarding an order for anxiety medication. The findings are: Review of Resident #4's current FL2 dated 04/12/18 revealed diagnoses included dementia, Alzheimer's disease, hypoglycemia, diabetic peripheral neuropathy, and generalized weakness. Review of Resident #4's physician's order dated	D 344		

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D 344	Continued From page 13 08/07/18, 09/04/18 and 11/06/18 revealed orders for lorazepam 0.5 mg one-half (0.25mg) three times a day at 8:00 am, 2:00 pm, and 8:00 pm for anxiety. (Lorazepam is used to treat anxiety and/or agitation). Review of Resident #4's physician's orders revealed: -There was a physician's order dated 11/06/18 for lorazepam 0.5 mg one tablet (0.5 mg) three times a day at 8:00 am, 2:00 pm, and 8:00 pm for anxiety. -There was a physician's order dated 11/13/18 for lorazepam 0.5 mg one-half tablet (0.25 mg) two times a day. -There was no clarification if Resident #4 should be receiving lorazepam 0.5 mg or 0.25 mg or if the dose should be administered 3 times a day or 2 times a day. Review of Resident #4's October 2018 medication administration record (MAR) revealed: -There was an entry for lorazepam 0.5 mg one-half (0.25mg) three times a day at 8:00 am, 2:00 pm, and 8:00 pm for anxiety. -Lorazepam 0.5 mg one-half tablet was documented as administered corectly at 8:00 am, 2:00 pm, and 8:00 pm daily from 10/01/18 to 10/31/18. Review of Resident #4's November 2018 MAR revealed: -There was an entry for lorazepam 0.5 mg one-half (0.25mg) three times a day at 8:00 am, 2:00 pm, and 8:00 pm for anxiety. -Lorazepam 0.5 mg one-half tablet was documented as administered at 8:00 am, 2:00 pm, and 8:00 pm daily from 11/01/18 to 11/30/18. -Lorazepam 0.5 mg one tablet (0.5 mg) three times a day at 8:00 am, 2:00 pm, and 8:00 pm	D 344		

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D 344	Continued From page 14 (ordered 11/06/18) was not transcribed on the MAR. -Lorazepam 0.5 mg one-half tablet (0.25 mg) two times a day (ordered on 11/13/18) was not transcribed on the MAR. Review of Resident #4's December 2018 MAR revealed: -There was a pre-printed entry for lorazepam 0.5 mg one-half tablet (0.25 mg) two times a day with administration scheduled at 8:00 am and 8:00 pm daily transcribed on the MAR. -The pre-printed entry for lorazepam 0.5 mg one-half tablet two times a day had been changed to read three times a day with 8:00 am, 2:00 pm and 8:00 pm scheduled times for administration. -Lorazepam 0.5 mg one-half tablet was documented as administered at 8:00 am, 2:00 pm, and 8:00 pm daily from 12/01/18 to 12/13/18. Review of Resident #4's record revealed: -There was no documentation Resident #4's provider had been contacted to clarify the conflicting orders dated 11/06/18 for lorazepam 0.5 mg one-half tablet (0.25 mg) 3 times a day and lorazepam 0.5 mg one tablet (0.5 mg) 3 times on 11/06/18. -There was no documentation Resident #4's provider was contacted regarding the order dated 11/13/18 for lorazepam 0.5 mg one-half (0.25 mg) two times a day being changed to 3 times a day. Telephone interview on 12/14/18 at 2:30 pm with a pharmacist at the contract pharmacy revealed: -The pharmacy had documentation for the receipt of the lorazepam 0.5 mg one tablet 3 times a day dated 11/06/18. The pharmacy received a phone call from a medication aide on 11/12/18 at 9:36 am informing the pharmacy that Resident #4 was supposed to be receiving lorazepam 0.5 mg	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041081	A. BUILDING: _____ B. WING _____	12/17/2018

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D 344	Continued From page 15 one-half tablet 3 times a day. The pharmacy put the order for lorazepam 0.5 mg 3 times a day on hold. -The pharmacy dispensed 90 doses of lorazepam 0.5 mg one-half (0.25 mg) labeled three times a day on 08/07/18, 09/10/18, 10/09/18, and 11/07/18. -The pharmacy received the order dated 11/13/18 for Resident #4's lorazepam 0.5 mg one-half tablet (0.25 mg) twice a day. The pharmacy adjusted Resident #4's MAR for December 2018 to reflect the change. The pharmacy dispensed lorazepam 0.5 mg one-half tablet (0.25 mg) two times a day on 12/01/18 for 30 tablets to equal 60 doses of one-half tablets on two bingo cards of 30 halves on each card. -The pharmacy had not received any documentation to change Resident #4's lorazepam 0.5 mg (0.25 mg) from 2 times a day to 3 times a day. Interview on 12/14/18 at 12:10 pm with the facility Nurse revealed the Resident Care Coordinator (RCC) was responsible for assuring medications were administered as ordered and any orders that were not clear should be clarified by the RCC or medication aides with the physicians. Interview on 12/14/18 at 4:45 pm with the Resident Care Coordinator (RCC) revealed: -She was responsible to assure medications were administered as ordered and orders clarified if needed. -The Executive Director was not involved in medication administration on a day to day basis. -New orders were received by the MA on duty at the time, faxed to the pharmacy, and transcribed to the MAR. Third shift medication aide staff filed the order in the residents' records. When the medication arrived, it is double checked by a MA	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 16 or the RCC for order accuracy and put on the medication cart. Medication orders that were not clear or conflicting should be clarified by the MA or RCC. -The new monthly MAR was compared to the previous month by third shift medication aide supervisor for the first check, and by the RCC as a second check. -The facility Nurse was supposed to do a third and final check of the MAR but that was not currently being done due to staff turnover and training/orientation of the facility Nurse. -She did not know why Resident #4's lorazepam was changed on the MAR and no documentation was available for the clarification. Telephone interview on 12/14/18 at 4:45 pm with Resident #4's Nurse Pratitioner with his primary care provider (PCP) revealed: -She ordered lorazepam 0.5 mg one-half tablet (0.25 mg) three times a day at 8:00 am, 2:00 pm, and 8:00 pm in August 2018 to help with the resident's anxiety. -She had written the lorazepam 0.5 mg one tablet 3 times a day on 11/06/18 as a refill and had written one tablet instead of one-half tablet in error. She remembered discussing to leave the resident on the one-half tablet 3 times a day but did not have documentation. The facility should have documentation if they call her. -She thought she wrote the new order on 11/13/18 to decrease lorazepam 0.5 mg one-half tablet two times a day to try the lower dose for the resident. She had no documentation the facility called her regarding clarification. -If Resident #4's activity level was good and he was not sedated, she would keep the resident on lorazepam 0.5 mg one-half (0.25 mg) 3 times a day; the facility needed to send a clarification for her to sign.	D 344		

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D 344	Continued From page 17 Based on interview and record review, the order for lorazepam 0.5 mg 3 times a day written on 11/06/18 and the order for lorazepam 0.25 mg 2 times a day written on 11/13/18 shoul have been clarified with Resident #4's Nurse Pratitioner with his primary care provider. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure administration of medications as ordered by a licensed	D 358		

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D 358	Continued From page 18 prescribing practitioner, which included errors with administration and omissions, for 3 of 5 sampled residents (#2, #4, and #5) related to sliding scale insulin and anti-anxiety medication (#4), a nasal spray and thyroid medication (#5), and an antifungal mouthwash (#2). The findings are: 1. Review of Resident #4's current FL2 dated 04/12/18 revealed diagnoses included dementia, Alzheimer's disease, hypoglycemia, diabetic peripheral neuropathy, and generalized weakness. a. Review of Resident #4's current FL2 dated 04/12/18 revealed: -There was an order for Levemir insulin (a long acting insulin used to lower elevated blood sugar levels) insulin 55 units every morning. -There was an order for Novolog insulin (a rapid acting insulin used to lower elevated blood sugar levels) 5 units after breakfast and lunch. Review of Resident #4's physician's orders dated 08/07/18, 09/04/18 and 11/06/18 revealed Novolog insulin three times a day, before meals use sliding scale insulin (SSI) coverage subcutaneously with parameters as follows: -Fingerstick blood sugar (FSBS) range between 150-200 give 2 units. -FSBS range between 201-250 give 4 units. -FSBS range between 251-300 give 6 units. -FSBS range between 301-350 give 8 units. -FSBS range between 301-350 give 8 units. -FSBS range between 351-400 give 10 units. -FSBS range between 401-450 give 12 units. -FSBS above 451 give 15 units and notify provider.	D 358		

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D 358	Continued From page 19 Review of Resident #4's medication administration record (MAR) for October 2018 revealed: -An entry for FSBS before meals and scheduled at 6:00 am, 11:30 am, and 4:30 pm. -An entry for Novolog insulin check fingerstick blood sugar (FSBS) before each meal and inject per SSI coverage as follows: 150-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; 401-450 = 12 units; FSBS above 451 give 15 units and notify provider. -FSBS results for October 2018 ranged from 84 to 470. -Novolog insulin per SSI was not documented for the amount administered for eight out of sixty-nine opportunities when sliding scale insulin should have been administered, and four opportunities when SSI was administered and no FSBS value was documented with examples as follows: -On 10/09/18 at 11:30 am, FSBS result was 340 and 8 units of Novolog SSI should have been administered, no SSI was documented as administered. -On 10/13/18 at 11:30 am, FSBS result was 213 and 4 units of Novolog SSI should have been administered, no SSI was documented as administered. -On 10/17/18 at 11:30 am 4 units of Novolog SSI was documented as administered, and no FSBS value was recorded on the MAR. -On 10/20/18 at 7:30 am 2 units of Novolog SSI was documented as administered, and no FSBS value was recorded on the MAR. Review of Resident #4's November 2018 MAR revealed: -An entry for FSBS before meals and scheduled at 6:00 am, 11:30 am, and 4:30 pm.	D 358		

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D 358	Continued From page 20 -An entry for Novolog insulin check FSBS before each meal and inject per SSI coverage as follows: 150-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; 401-450 = 12 units; FSBS above 451 give 15 units and notify provider. -FSBS results for November 2018 ranged from 72 to 472. -Novolog insulin per SSI was not documented for the amount administered for two out of seventy-one opportunities when sliding scale insulin should have been administered, and six out of seventy-one opportunities when SSI was administered incorrectly for FSBS value documented with examples as follows: -On 11/01/18 at 11:30 am, FSBS result was 166 and 2 units of Novolog SSI should have been administered, no SSI was documented as administered. -On 11/19/18 at 7:30 am, FSBS result was 210 and 4 units of Novolog SSI should have been administered, no SSI was documented as administered. -On 11/15/18 at 11:30 am, FSBS result was 363 and 4 units of Novolog SSI was documented as administered; 10 units should have been administered. -On 11/21/18 at 11:30 am, FSBS result was 304 and 6 units of Novolog SSI was documented as administered; 8 units should have been administered. Review of Resident #4's December 2018 MAR revealed: -An entry for FSBS before meals and scheduled at 6:00 am, 11:30 am, and 4:30 pm. -An entry for Novolog insulin check FSBS before each meal and inject per SSI coverage as follows: 150-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 =	D 358		

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D 358	Continued From page 21 10 units; 401-450 = 12 units; FSBS above 451 give 15 units and notify provider. -FSBS results for December 2018 ranged from 98 to 367. -Novolog insulin per SSI was administered incorrectly for FSBS value documented one out of twenty-one opportunities; on 12/05/18 at 11:30 am, FSBS result was 225 with 5 units of Novolog SSI documented as administered; 6 units should have been administered. Interview with the facility Nurse (FN) on 12/14/18 at 12:00 pm revealed: -The Resident Care Coordinator (RCC) was responsible to assure medications were administered as ordered. -The RCC should be checking the residents' MARs for accuracy of medication administration as well as for missed medication (holes) on the MAR. -She did not know Resident #4's Novolog SSI was not administered as ordered in October, November, and December 2018. Interview on 12/14/18 at 3:15 pm with the RCC revealed: -She was responsible for monitoring the medication aides (MAs) and to assure residents' medications were administered as ordered. -She was responsible to review residents' MARs for medication administration. -She had not audited Resident #4's MARs in several months. -Shift MA Supervisors were responsible to assist with monitoring medication administration and documentation at the end of their shifts. Telephone interview on 12/14/18 at 4:45 pm with Resident #4's primary care provider (PCP) revealed:	D 358		

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D 358	Continued From page 22 -The PCP expected the facility to administer insulin as ordered and should be documenting the amount administered. -She would be more concerned with low FSBS values than high FSBS value. -It was important to obtain FSBS values in order to properly monitor Resident #4's blood sugar level. -It was important to administer SSI as ordered to control elevated blood sugar levels and manage the residents' diabetes. Interview on 12/14/18 at 4:45 pm with a second shift medication aide (MA) revealed: -She was responsible to obtain FSBS checks and administer insulin to residents during her shift. -The MA should be documenting FSBS values on the resident's MAR or the facility blood glucose monitoring monthly log sheet, and SSI administration on the MAR. -She did not know why FSBS values were not recorded as ordered three times a day in October 2018 and November 2018. -If there were empty spaces on the MAR, then a MA must have gotten distracted and did not document the administration. -MAs were supposed to check the MARs at the end of their shifts for documenting medication administration. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Interview on 12/17/18 at 6:30 pm with the Executive Director revealed the RCC was responsible to assure medications were administered as ordered. b. Review of Resident #4's physician's order	D 358		

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D 358	Continued From page 23 dated 08/07/18 and signed physicians' orders dated 09/04/18 and 11/06/18 revealed orders for lorazepam 0.5 mg one-half (0.25mg) three times a day at 8:00 am, 2:00 pm, and 8:00 pm for anxiety. Review of Resident #4's record revealed: -There was a signed physician's orders dated 11/06/18 for lorazepam 0.5 mg one tablet (0.5 mg) three times a day at 8:00 am, 2:00 pm, and 8:00 pm for anxiety. -There was a signed physician's orders dated 11/13/18 for lorazepam 0.5 mg one-half tablet (0.25 mg) two times a day. Review of Resident #4's November 2018 MAR revealed: -Lorazepam 0.5 mg one-half tablet (0.25 mg) two times a day (ordered on 11/13/18) was not transcribed on the MAR. -There was an entry for lorazepam 0.5 mg one-half (0.25mg) three times a day at 8:00 am, 2:00 pm, and 8:00 pm for anxiety. -Lorazepam 0.5 mg one-half tablet was documented as administered at 8:00 am, 2:00 pm, and 8:00 pm daily from 11/01/18 to 11/30/18. -Lorazepam 0.25 mg was documented as administered for 17 doses at 2:00 pm in November 2018 after the dose was discontinued 11/13/18 (2:00 pm dose should not have been administered). Review of Resident #4's December 2018 MAR revealed: -There was a pre-printed entry for lorazepam 0.5 mg one-half tablet (0.25 mg) two times a day with administration scheduled at 8:00 am and 8:00 pm daily transcribed on the MAR. -The pre-printed entry for lorazepam 0.5 mg one-half tablet two times a day had been changed	D 358		

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D 358	Continued From page 24 to read three times a day with 8:00 am, 2:00 pm and 8:00 pm scheduled times for administration (with the subsequent order to change to twice a day on 11/13/18). -Lorazepam 0.5 mg one-half tablet (0.25mg) was documented as administered at 8:00 am, 2:00 pm, and 8:00 pm daily from 12/01/18 to 12/13/18. -Lorazepam 0.25 mg was documented as administered incorrectly 13 times at 2:00 pm dose in December 2018, after the discontinue order change to 2 times a day dated 11/13/18. Telephone interview on 12/14/18 at 2:30 pm with a pharmacist from the contracted pharmacy revealed: -The pharmacy received the order dated 11/13/18 for Resident #4's lorazepam 0.5 mg one-half tablet (0.25 mg) twice a day. The pharmacy adjusted Resident #4's MAR for December 2018 to reflect the change. The pharmacy dispensed lorazepam 0.5 mg one-half tablet (0.25 mg) two times a day on 12/01/18 for 30 tablets to equal 60 doses of one-half tablets on two bingo cards of 30 one-half tablets on each card. -The pharmacy had not received any documentation to change Resident #4's lorazepam 0.5 mg (0.25 mg) from two times a day to three times a day. Based on review of Resident #4's physician order dated 11/13/18 and documentation of administration of lorazepam 0.5 mg (one half tablet), Resident #4 was administered 30 doses of lorazapam 0.5 mg one-half tablet (0.25mg) at 2:00 pm from 11/14/18 to 12/13/18 without a physician's order. Interview on 12/14/18 at 12:10 pm with the facility Nurse revealed the Resident Care Coordinator (RCC) was responsible for assuring medications	D 358		

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D 358	Continued From page 25 were administered as ordered; she did not know Resident #4 was receiving lorazepam incorrectly. Interview on 12/14/18 at 4:45 pm with the Resident Care Coordinator (RCC) revealed: -She was responsible to assure medications were administered as ordered. -The Executive Director was not involved in medication administration on a day to day basis. -New orders were received by the MA on duty at the time, faxed to the pharmacy, and transcribed to the MAR. Third shift medication aide staff filed the order in the residents' records. When the medication arrived, it was double checked by a MA, or the RCC, for order accuracy and put on the medication cart. -The new monthly MAR was compared to the previous month by a third shift medication aide supervisor for the first check, and by the RCC as a second check. -The facility Nurse was supposed to do a third and final check of the MAR but that was not currently being done due to staff turnover and training/orientation of the facility Nurse. -She did not know why Resident #4's lorazepam was changed on the MAR. -She did not have a system in place to audit resident records for medication orders compared to the information entered on the MARs. Telephone interview on 12/14/18 at 4:45 pm with Resident #4's primary care provider (PCP) revealed: -She ordered lorazepam 0.5 mg one-half tablet (0.25 mg) three times a day at 8:00 am, 2:00 pm, and 8:00 pm in August 2018 to help with the resident's anxiety. -She thought she wrote the new order on 11/13/18 to decrease lorazepam 0.5 mg one-half tablet two times a day to try the lower dose for the	D 358		

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D 358	Continued From page 26 resident. -She did not know Resident #4 was receiving lorazepam three times a day instead of two times a day as ordered on 11/13/18. -She expected the facility to assure medications were administered as ordered. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. 2. Review of Resident #5's current FL2 dated 03/28/18 revealed diagnoses included dementia, hypothyroidism, anemia, congestive heart failure and depression. a. Review of Resident #5's FL2 revealed an order for Synthroid (used to replace thyroid hormone) 100 mcg daily. Review of Resident #5's record revealed a Thyroid Stimulating Hormone lab value dated 05/15/18 of 0.35 uU/ml (the normal reference range is 0.5 to 4.5 uU/ml). Review of Resident #5's physician orders dated 07/10/18, 09/04/18 and 11/16/18 revealed orders for Synthroid 100 mcg daily. Review of Resident #5's October 2018 Medication Administration Record (MAR) revealed: -There was an entry for Synthroid 100 mcg scheduled for administration at 6:00 am daily. -There was no documentation of administration from 10/03/18 to 10/11/18 as indicated by staff circled initials for Synthroid was not administered. -Documentation on the back of the MAR included, "waiting on pharmacy" and "not available".	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041081	A. BUILDING: _____ B. WING _____	12/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND PLACE	3823 LAWNDALE DRIVE GREENSBORO, NC 27455

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D 358	Continued From page 27 Telephone interview on 12/14/18 at 2:30 pm with a pharmacy representative with the contract pharmacy revealed: -The pharmacy had documentation for the receipt of the Synthroid 100 mcg one daily order on 03/18/18. -The pharmacy filled the order on 03/29/18, 05/11/18, 06/27/18, 08/06/18, 10/17/18 and 11/23/18 with 30 tablets each time. -The facility staff must request refills when needed. Interview on 12/14/18 at 3:00 pm with a medication aide (MA) revealed: -The facility staff called the pharmacy and requested medication refills when needed. -She remembered when Resident #5 missed several doses "it was more than a week, but I don't remember exactly"of Synthroid 100 mcg in October 2018. -The physician did not sign the order, and the pharmacy would not fill the prescription until the order was completed. -When the order was clarified, the pharmacy filled the prescription. Interview on 12/14/18 at 12:10 pm with the facility Nurse revealed: -The Resident Care Coordinator (RCC) was responsible for assuring medications were administered as ordered. -She did not know the Synthroid was not administered as ordered for nine days. Interview on 12/17/18 at 4:45 pm with the Resident Care Coordinator revealed: -She was responsible to assure medications were administered as ordered. -The synthroid was ordered by Resident #5's	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 28 previous physician. -The order was not signed by the physician, so the pharmacy would not fill it until the order was clarified. -The facility attempted to contact the physican several times, with no response from the physician. -After nine missed doses, the physician responded and the facility staff resent the order to the pharmacy. -She did not have a system in place to audit resident records for medications orders compared to the information entered on the MARs. Telephone interview on 12/14/18 at 3:40 pm with Resident #5's primary care provider revealed: -The Synthroid was ordered by Resident #5's previous primary care provider. -She knew of the missed doses of Synthroid for Resident #5. -The facility staff was timely with notifications about missed medication doses, and notified her when needed. -She expected the facility to assure medications were administered as ordered. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. b. Review of Resident #5's physician's order dated 10/22/18 revealed for Flonase, 2 sprays each nostril every day (Flonase is used to treat nasal congestion, sneezing, runny nose and itchy or water eyes caused by seasonal allergies). Review of Resident #5's October 2018 medication administration record (MAR) revealed: -There was a handwritten entry for Flonase two	D 358		

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D 358	Continued From page 29 sprays each side of nose, once a day, beginning 10/24/18. -The 10/24/18 entry was blank, with no documentation of administration. -There was no documentation of administration from 10/25/18 to10/31/18 as indicated by staff initials circled as not administered. -There was documentation on the back of the MAR indicating "waiting on pharmacy"and "not available". Review of Resident #5's November 2018 MAR revealed: -There was a handwritten entry for Flonase, two sprays each side of nose, once a day. -The 11/01/18 and 11/02/18 entries each had circled initials, indicating the medication was not given. -There was no documentation on the back of the MAR indicating why the Flonase was not administered. Telephone interview on 12/14/18 at 2:30 pm with a pharmacy representative from the contracted pharmacy revealed: -The pharmacy had documentation for the receipt of the Flonase order, two sprays each side of the nose, once a day on 10/24/18. -The pharmacy filled the order on 11/17/18. -"I'm not sure why we didn't fill it sooner. There is no documentation to explain that". Interview on 12/14/18 at 12:10 pm with the facility Nurse revealed: -The Resident Care Coordinator (RCC) was responsible for assuring medications were administered as ordered. -She did not know the Flonase was not administered for nine days.	D 358		

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D 358	Continued From page 30 Interview on 12/18/18 at 4:45 pm with the RCC revealed: -She was responsible to assure medications were administered as ordered. -The Flonase was ordered by Resident #5's previous physician. -The order "was not the correct dosage", so the pharmacy would not fill it until the order was clarified. -The facility attempted to contact the physican for order clarification several times, with no response from the physician. -After nine missed doses of Flonase, the physician responded and the order was corrected. -She did not have a system in place to audit resident records for medications orders compared to the information entered on the MARs. Telephone interview on 12/14/18 at 3:40 pm with Resident #5's primary care provider revealed: -She knew of the delay in the start of the Flonase for Resident #5. -The facility was "timely with notifications about medication delays". -She expected the facility to assure medications were administered as ordered. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. 3. Review of Resident #2's current FL2 dated 08/07/18 revealed diagnoses included dementia, hypertension, dysphagia, muscle weakness, anxiety and depression. Review of Resident #2's physician's order dated 11/13/18 for nystatin swish (used as an	D 358		

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D 358	Continued From page 31 anti-fungal mouthwash), gargle and swallow six ml, four times daily for 14 days. Review of Resident #2's November 2018 medication administration record (MAR) revealed: -A handwritten entry for nystatin swish, gargle and swallow six ml, four times daily for 14 days dated 11/14/18. -There were thirty-eight of fifty-six opportunities nystatin was not documented as administered as indicated by staff initials circled. -There was documentation on the back of the MAR which indicated "waiting on medication", "med not here" and "waiting on pharmacy". -Ten of the fifty-six administration opportunities were blank, with no documentation of administration. Review of Resident #2's December 2018 MAR revealed: -There was no entry for nystatin swish, gargle and swallow six ml, four times daily for 14 days. -There was no documentation nystatin swish was administered. Observation of medications on hand for Resident #2 on 12/14/18 at 3:15 pm revealed: -An opened 336 ml bottle of nystatin prescribed to Resident #2. -The label was transcribed as nystatin swish, gargle and swallow six ml, four times daily for 14 days. -The nystatin was dipensed on 11/24/18. -The bottle of mystatin was almost full. Telephone interview on 12/14/18 at 2:30 pm with a pharmacy representative from the contracted pharmacy revealed: -The pharmacy had documentation for the receipt of the nystatin swish order 11/24/18.	D 358		

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D 358	Continued From page 32 -The nystatin swish order was dated 11/14/18, but the pharmacy did not receive the order until 11/24/18. -The pharmacy dispensed the order on 11/24/18. -The pharmacy filled the order with 336 ml, which was a 14 day supply. Interview on 12/14/18 at 12:10 pm with the facility Nurse revealed: -The Resident Care Coordinator (RCC) was responsible for assuring medications were administered as ordered. -She did not know the nystatin was not administered as ordered. -She did not know Resident #2 had only received eight of the fifty-six doses. Interview on 12/18/18 at 4:45 pm with the Resident Care Coordinator revealed: -She was responsible to assure medications were administered as ordered. -The pharmacy needed the order to be clarified before they would fill it. -Then the clarification was postponed a week, due to the provider being unavailable, so the prescription was filled on 11/24/18. -The order was not carried over to the December MAR, because it was apparently overlooked. -"They probably thought the order was finished". -She did not know Resident #2 had only received eight of the fifty-six doses. -She did not have a system in place to audit resident records for medication orders compared to the information entered on the MARs. Telephone interview on 12/14/18 at 3:40 pm with Resident #2's primary care provider revealed: -She had ordered the nystatin for Resident #2 on 11/14/18 because "he indicated his mouth hurt". -Resident #2 had not lost any weight, but he	D 358		

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D 358	Continued From page 33 "appeared gaunt". -She did not know Resident #2 had only received eight of the fifty-six doses of the nystatin ordered. -She was not notified by the facility about the need for a nystatin order clarification. -She had seen Resident #2 since the nystatin order was written, and he appeared to be doing well. -She would consider renewing the nystatin order, since Resident #2 had only received eight doses. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Attempt to interview Resident #2's family member was unsuccessful. The facility failed to assure medications were administered as ordered to 3 of 5 sampled residents (#2, #4, and #5) related to sliding scale insulin and anti-anxiety medication (#4), a nasal spray and thyroid medication (#5), and an antifungal mouthwash (#2). This failure of not receiving medications as ordered could result in failure to treat diseases properly and increased risk of exacerbations of clinical symptoms which was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G. S. 131D-34 on 12/14/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2019.	D 358		

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D 468	Continued From page 34	D 468		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff C) assigned to the Special Care Unit had	D 468		

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D 468	Continued From page 35 completed 6 hours of orientation during the first week of employment and completed 20 hours of training specific to the population being served within six months of employement. The findings are: Review of Staff C, medication aide's (MA) personnel record revealed: -Staff C was hired on 06/06/17. -There was documentation of four hours of SCU training completed on 06/26/17. -There was documentation of two additional hours of SCU orientation completed between the dates of 06/26/17 and 12/31/17. Interview on 12/17/18 at 6:45 pm with the Resident Care Coordinator (RCC) revealed the Business Office Manager (BOM), facility Nurse, or Memory Care Manager were responsible for assuring new employee training, and requirements were completed upon hire or within the required timeframes. Interview on 12/17/18 at 7:00 pm with the Executive Director (ED) revealed: -She knew about the requirement for completion of 6 hours of special care unit training during the first week of employment for any SCU employee. -She was also aware of the requirement for an additional 20 hours of special care unit training to be completed within 6 months of hire for any SCU employee. -She did not know Staff C had not completed 20 hours of SCU training in 2017. -She did not know if staff personnel records were reviewed after the hiring process was completed. -Staff qualifications and training records were in many different files and it was difficult to locate needed documents.	D 468		

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D 468	Continued From page 36 -The ED was responsible for assuring all staff qualifications and training had been completed. Telephone interview on 12/18/18 at 10:03 am with Staff C revealed: -The BOM and the facility Nurse verified her credentials online when she was hired. -She completed a four dementia basics training on 06/26/17 and another 2 hours with the first week using the facility training web site. -She did not have a total of 20 hours of additional training in care of residents with dementia within 6 months of hire -She was not told by the facility Nurse, BOM or any administration that she need to complete 20 additional hours by the end of 2017 (6 months from hire).	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate and in compliance with federal and state laws and rules and regulations related to medication administration, Health Care Personnel Registry check, and medication aide training and competency evaluation requirements, and other	D912		

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D912	Continued From page 37 staff requirements. The findings are: 1. Based on observation, interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff were tested for tuberculosis (TB) upon hire (Staff B) and completed the 2nd TB skin test (Staff A). [Refer to Tag D0131, 10A NCAC 13F .0406(a) Test for Tuberculosis (Type B Violation).] 2. Based on observations, record reviews and interviews, the facility failed to ensure that each staff person had no substantiated findings listed on the North Carolina Health Care Personnel Registry for 1 of 3 sampled staff (Staff A). [Refer to Tag D0137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to assure administration of medications as ordered by a licensed prescribing practitioner, which included errors with administration and omissions, for 3 of 5 sampled residents (#2, #4, and #5) related to sliding scale insulin and anti-anxiety medication (#4), a nasal spray and thyroid medication (#5), and an antifungal mouthwash (#2). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).] 4. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 2 sampled staff (Staff B and Staff C) who administered medications, had employment verification or completed the 5,10, or 15 hour medication administration training courses and completed a Medication Clinical Skills Competency validation prior to administering	D912		

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D912	Continued From page 38 medications. [Refer to Tag D0935, G.S. 131D-4.5B(b) ACH Medication Aides; Training and Competency (Type B Violation).]	D912		
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 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	D935		

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D935	Continued From page 39 Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 2 of 2 sampled staff (Staff B and Staff C) who administered medications, had employment verification or completed the 5,10, or 15 hour medication administration training courses and completed a Medication Clinical Skills Competency validation prior to administering medications. The findings are: 1. Review of Staff C, medication aide (MA) Supervisor's personnel record revealed: -Staff C was hired on 06/06/17. -There was documentation Staff C had completed the Medication Clinical Skills Competency validation on 07/05/17. -There was documentation Staff C passed the written medication administration examination on 04/27/15. -There was no documentation of employment verification showing Staff C worked as a	D935		

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D935	Continued From page 40 medication aide within the past 24 months. -There was no documentation Staff C had completed the 5,10, or 15 hour medication aide training. Review of a resident's November 2018 medication administration record (MAR) revealed Staff C documented administration of medications on 11/01/18, 11/03/18, 11/04/18, 11/07/18, 11/08/18, and from 11/12/18 to 11/15/18. Review of a resident's December 2018 MAR revealed Staff C documented administration of medications on 12/02/18, 12/05/18, 12/06/18, 12/11/18, 12/12/18, and 12/13/18. Telephone interview on 12/18/18 at 10:03 am with Staff C revealed: -She had worked at the facility since June 2018. -She worked the morning shift Monday through Friday, and she worked the morning shift every other weekend. -She had taken a 5,10/15 hours medication aide training at another facility prior to taking and passing the medication aide test on 04/27/15, but she did not have a copy of the training to provide to the facility. -She worked at 2 other facilities, and a factory for a short time prior to starting at the facility in June 2017. -She thought the facility's Nurse had contacted the facility where she previously worked as a medication aide, but she did not have a copy of the verification. -She had not been asked by the facility administration to retake the 5,10, or 15 hour medication aide training. Interview on 12/17/18 at 4:50 pm with the	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041081	A. BUILDING: _____ B. WING _____	12/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND PLACE	3823 LAWNDALE DRIVE GREENSBORO, NC 27455

(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
D935	Continued From page 41 Business Office Manager (BOM) revealed she did not have previous employment verification for Staff C. Interview on 12/17/18 at 6:50 pm with the facility Nurse revealed: -She was employed after Staff C was hired. -She was providing medication aide staff with training. -She had not audited the personnel records for any staff, so she did not know if Staff C had previous employment as a medication aide in the last 24 months or the 5,10 or 24 hour medication aide training. Refer to interview on 12/17/18 at 7:00 pm with the Executive Director (ED). 2. Review of Staff B, medication aide's (MA) personnel record revealed: -Staff B was hired on 08/07/18. -There was documentation Staff B passed the written medication administration exam on 06/29/16. -There was no documentation of employment verification showing Staff B worked as a medication aide within the past 24 months. -There was no documentation Staff B had completed the 5, 10, or 15 hour medication aide training. -There was no documentation of completion of medication clinical skills competency validation. Review of a resident's October 2018 medication administration record (MAR) revealed Staff B documented administration of medications on 10/02/18, 10/03/18, 10/05/18, 10/13/18, 10/14/18, 10/16/18, 10/23/18, and 10/29/18. Review of a resident's November 2018 MAR	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041081	A. BUILDING: _____ B. WING _____	12/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND PLACE	3823 LAWNDALE DRIVE GREENSBORO, NC 27455

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D935	Continued From page 42 revealed Staff B documented administration of medications on 11/02/18, 11/10/18, 11/13/18, and 11/23/18. Telephone interview on 12/18/18 at 2:15 pm with Staff B revealed: -She had worked at the facility since July 2018. -She had worked at another care facility prior to employment at the present facility. -She had not been asked by the facility administration to take the 5, 10, or 15 hour medication aide training. -A medication clinical skills competency validation was not completed prior to her performing unsupervised medication aide duties. Interview on 12/17/18 at 4:50 pm with the Business Office Manager (BOM) revealed: -She did not have previous employment verification for Staff B. -She was unaware of the requirement for the 5, 10, or 15 hour medication aide training. Interview on 12/17/18 at 6:50 pm with the facility Nurse revealed: -She was providing medication aide staff with training. -She had not audited the personnel records for any staff. -She did not know if Staff B had previous employment as a medication aide in the last 24 months or the 5,10 or 15 hour medication aide training. Refer to interview on 12/17/18 at 7:00 pm with the Executive Director (ED). Interview on 12/17/18 at 7:00 pm with the ED revealed: -Currently the facility Nurse and the BOM were	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041081	A. BUILDING: _____ B. WING _____	12/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D935	Continued From page 43 responsible for ensuring staff qualifications were completed as required. -She did not know if the employee records were reviewed after the hiring process was completed. -Staff qualifications and training were in many different files and it was difficult to locate needed documents. -She did not know staff needed documentation for employment as a medication aide within the last 24 months or a completed 5, 10, or 15 hour medication training before staff could pass medications at the facility. -The ED was responsible for assuring all staff qualifications had been completed. The facility failed to assure 2 medication aides had received medication administration training and completed a medication aide clinical skills competency validation prior to performing unsupervised medication aide duties, which placed all residents at risk for medication errors. The facility's failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/17/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2019.	D935		

D131 10A NCAC 13F .0406(a) Test for Tuberculosis

Staff A received her TB test on and it was read on 12/21/18.

Staff B's TB documentation has been located and is in her employee file.

Current associates who are missing their second step TB test will have another TB series initiated by 2/8/19.

The Care Services Manager (CSM) is responsible for sustained compliance. The Executive Director (ED) and/or designee will audit new employee files within 15 day of hire to ensure the second step TB test has been initiated and documented for the next 3 months. Audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.

Completion date: February 8, 2019

D137 10A NCAC 13F .0407(a)(5) Other Staff Qualification

Staff A is no longer employed at the community. The Business Office Manager (BOM) was re-educated on the requirement to complete HCPR checks on 12/17/18 by Ray Peedin from DHHS.

Current associates who were missing their HCPR documentation were printed and in the employee file by 1/31/19.

The Business Office Manager (BOM) is responsible for sustained compliance. The ED and/or designee will audit new employee files within 3 days of hire and prior to contact with residents to ensure the HCPR check has been completed and results are in the employee file for the next 3 months. Audit results will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.

Completion date: January 31, 2019

D161 10A NCAC 13F .0504(a) Competency Validation for LHPS Tasks

Staff B will have completed the LHPS Competency Validation by 2/15/19.

The current CSM was educated on the requirement for LHPS competency validation on 12/18/18 by Ray Peedin from DHHS.

Current associates who are missing their LHPS validation documentation will be completed by 2/28/19.

The CSM is responsible for sustained compliance. The ED and/or designee will audit 5 employee files/week for 4 weeks, then 3 employee files/wee for 4 weeks, then 1 employee file/week for 4 weeks, to ensure completion of LHPS competency validation. Audit result will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.

Completion date: February 28, 2019

D164 10A NCAC 13F .0505 Training On Care Of Diabetic Resident

Staff B will have completed training on care of diabetic residents by 2/15/19.

CSM will provide training on the basic facts about diabetes and care involved in the management of diabetes. This will include insulin action, insulin storage, mixing, measuring and injection techniques for insulin administration, treatment and prevention of hypoglycemia and hyperglycemia, including sign and symptoms, blood glucose monitoring; universal precautions, appropriate administration times, and sliding scale insulin administration

Current staff who pass medications will be retrained on care of diabetic residents by 2/15/19.

The CSM is responsible for sustained compliance. The ED and/or designee will audit new employee files for employees hired to pass medications within 5 days of hire to ensure completion of care of diabetic residents training for 3 months. Audit result will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.

Completion date: February 15, 2019

D273 10A NCAC 13F .0902(b) Health Care

Resident #1's Cardiology referral appointment was scheduled for 1/15/19; resident refused to go. A second appointment was scheduled for 1/29/19.

The Resident Care Coordinator (RCC) was re-trained on reviewing new orders and scheduling appointments on 12/18/18 by the ED.

The CSM is responsible for sustained compliance. The ED and/or designee will review physician orders during routine morning meetings 5 times per week, then 3 times per week, then 1 time per week, to

ensure orders for appointments are scheduled and followed up on. Audit result will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.

Completion date: February 15, 2019

D344 10A NCAC 13F .1002(a) Medication Orders

Resident #4's lorazepam order was clarified with the Nurse Practitioner on 12/17/18.

The Med Aides (MA) and RCC were re-educated by 2/8/19 by ED and CSM on new orders and verification contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments; If orders for admission or readmission of the resident to the community if not dated and signed within 24 hours of admission or readmission If orders are not clear or complete; If multiple admission forms are received upon admission or readmission and orders on the forms are not the same

The RCC is responsible for sustained compliance. The CSM and/or designee will audit current physician orders for 5 residents/week for 4 weeks, then 3 residents/week for 4 weeks, then 1 resident/week for 4 weeks to ensure the orders are correct. Audit result will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.

Completion date: February 15, 2019

D358 10A NCAC 13F .1004(a) Medication Administration

CSM and/or designee will re-educate Med Aids on proper medication administration and documentation by 2/28/19.

The CSM is responsible for sustained compliance. The CSM and/or designee will review MARs 5 times per week, then 3 times per week, then 1 time per week, to ensure orders for appointments are scheduled and followed up on. Audit result will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.

Completion date: February 28, 2019

D468 10A NCAC 13F .1309 Special Care Unit Staff Orientation and Training

ED and/or designee, will ensure a plan is in place for associates to receive at least 20 hours of training specific to the population to be served in the Special Care Unit, identifying content, texts, sources, evaluations and schedules regarding training achievement.

Within the first week of employment, each employee shall complete six hours of orientation on the nature and needs of the residents in a Special Care Unit.

Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the populations being served in addition to the training competency requirements.

Staff responsible for personal care and supervision with in the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

The ED and/or designee will audit new employee files within 15 day of hire to ensure initial training hours have been met. Audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.

Completion date: February 28, 2019

D912 G.S. 131D-21(2) Declaration of Residents' Rights

Refer to plan of correction for Tags D131, 10A NCAC 13F .0406(a) Test for Tuberculosis; D137, 10A NCAC 13F .0407(a)(5) Other Staff Qualification; D358, 10A NCAC 13F .1004(a) Medication Administration; and D935, G.S. 131D-4.5B(b) ACH Medication Aides; Training and Competency.

Completion date: February 28, 2019

D935 G.S. 131D-4.5B(b) ACH Medication Aides; Training and Competency

ED, CSM and BOM were re-educated on this rule area by Ray Peedin with DHHS on 12/17/18.

BOM and/or designee will attain documentation that all staff who administer medications have employment verification or have completed the 5, 10, or 15 hour medication administration training

courses and completed a Medication Clinical Skills Competency validation prior to administering medications.

The CSM is responsible for sustained compliance. The ED and/or designee will audit new employee files for employees hired to pass medications within 5 days of hire to ensure completion of verification for 3 months. Audit result will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.

Completion date: February 28, 2019