STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: ___ B. WING ___	R 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(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 and follow-up survey on April 9, 2019 through April 11, 2019.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidenced by storage of oxygen tanks in an unsafe manner in resident room #7, a missing light switch cover and electrical outlet cover in resident room #6, and two missing electrical outlet covers in the residents' dayroom. The findings are: 1. Review of Resident #5's FL-2 dated 07/17/18 revealed: -Diagnoses included muscle weakness, shortness of breath, and bipolar disorder. -She was semi-ambulatory with a rollator and was intermittently disoriented. -There was an order for continous oxygen at 3	D 079		

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D 079	Continued From page 1	D 079		

liters per minute for Resident #5.

Observation of Resident #5's room on 04/09/19 at 12:48pm revealed:
-Resident #5 resided in resident room #7.
-There werre five unsecured oxygen canisters standing upright on the floor between two night stands that were not racked.
-There was no resident or staff in the room.

Interview with one of the residents who resided in room #7 on 04/10/19 at 12:15pm revealed the oxygen canisters were often setting directly on the floor and not in the holder.

Interview with the Resident Care Coordinator (RCC) on 04/09/19 at 2:25pm revealed:
-The oxygen canisters were always stored in the Resident #5's room.
-She did not know how long the oxygen canisters had been setting unracked on the floor in resident room #7.
-The medical equipment provider delivered the canister to the resident's room.
-She knew the oxygen canisters were supposed to be stored in the metal rack.

Interview with the medical equipment provider on 04/11/19 at 10:00am revealed:
-He delivered the oxygen for Resident #5 who resided at the facility.
-He brought Resident #5's new oxygen canisters in a storage rack that held twelve canisters.
-The oxygen canisters were supposed to be stored in the oxygen storage rack for safety.
-If additional oxygen storage racks were needed, the facility could call the medical equipment provider and they could provide an additional storage rack that could hold six oxygen canisters.

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D 079	Continued From page 2	D 079		

Interview with the Administrator on 04/10/19 at 8:55am revealed:
-She knew Resident #5's oxygen canisters were stored in a storage rack in resident room #7 and none of the oxygen canisters were supposed to be stored unracked on the floor.
-She did not know five oxygen canisters were left unracked on the floor in Resident #5's room.
-The facility did not have an oxygen storage area and the oxygen canisters were stored in the Resident #5's roomt.
-The facility had purchased a metal rack to securely store the oxygen canisters (time nonspecified when the metal rack was purchased).
-She had asked staff to make sure the oxygen canisters were being placed back in the metal rack in room #7.

2. Observation of the residents' dayroom on 04/09/19 at 10:03am revealed:
-The outlet cover was missing from the electrical outlet located on the left wall adjacent to a bookcase.
-The outlet cover was missing from the electrical outlet used for the heating/air conditioning unit in the dayroom.

Observation of resident room #6 on 04/09/19 at 10:59am revealed:
-There was a missing outlet cover for an overhead bedside light switch located on the right adjacent to the head of a resident's bed and the overhead bedside light was on over the resident's bed.
-There was a missing outlet cover for the electrical outlet located on the wall next to the resident's nightstand.

Interview with a resident who resided in resident

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D 079	Continued From page 3	D 079		

room #6 on 04/09/19 at 11:00am revealed:
-The bedside light switch and electric outlet covers had been removed about five or six months ago when the facility was sprayed for bedbugs.
-She was not sure who removed the electric outlet covers in the room and she did not know why the covers had not been replaced.
-She had not complained to anyone about the missing outlet covers.
-She did not know anything about the missing outlet covers in the residents' dayroom.

Observation of the residents' dayroom on 04/10/19 at 8:35am revealed:
-The electrical outlet located on the left wall adjacent to a bookcase had been replaced.
-The electrical outlet used for the heating/air conditioning unit had not been replaced.

Interview with a housekeeper on 04/10/19 at 8:55am revealed:
-He was asked by the Administrator last week to check the facility for missing electrical outlet covers.
-He checked the facility last week for missing electrical outlet covers and did not see any.
-He did not notice the missing electrical outlet covers in the dayroom or in resident room #6.

Interview with the Resident Care Coordinator (RCC) on 04/09/19 at 2:25pm revealed:
-She did not kown the electrical outlet covers were missing in the dayroom or in resident room #6.
-She did know the electrical outlet covers had been removed in August 2018 when the facility had been sprayed for bedbugs.
-She did not know why the electrical outlet covers had not been replaced.

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CLASSIC CARE HOMES # 1	**101 ANNIE PARKER CIRCLE** **SMITHFIELD, NC 27577**

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D 079	Continued From page 4	D 079		

Interview with the Administrator on 04/10/19 at 8:50am revealed:
-She did not know there were electrical outlet covers that had not been replaced in the facility.
-She asked the housekeeper last week to check the facility for missing electrical outlet covers.
-The electrical outlet covers had been removed in October 2018 when the facility was sprayed for bedbugs.
-The electrical outlet used for the heating/air conditioning unit and the electrical outlet cover in room #6 had not been replaced because the wrong outlet covers had been purchased.

Observation of resident room #6 on 04/11/19 at 5:35pm revealed:
-The outlet cover for the overhead bedside light switch was still missing the outlet cover.
-The outlet cover for the electrical outlet located on the wall next to the resident's nightstand had been replaced.

____

The facility failed to ensure electrical outlet covers were installed and oxygen cylinders were stored securely in storage racks, creating a potential for an unsecured cylinder to fall and/or be knocked over, damaging the valve, and rapidly releasing the high pressure gas from the cylinder, could potentially cause injury. The facility's failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/09/19 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 26,

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 079	Continued From page 5 2019.	D 079		
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 interviews and record reviews, the facility failed to assure 3 of 4 sampled staff (Staff A, C, and D) were tested for tuberculosis (TB) disease upon hire. The findings are: Review of the facility's current license revealed the facility underwent a change of ownership effective 09/20/18. 1. Review of Staff A's, supervisor, personnel record revealed: -Staff's A date of hire was documented as 01/28/19. -There was documentation of a TB skin test was administered on 06/26/18 and the TB result was read as negative on 06/28/18. -There were no other TB skin test results on	D 131		

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D 131	Continued From page 6 record for Staff B. Attempted telephone interview with Staff A on 04/11/19 at 4:25pm was unsuccessful. Refer to interview with the Administrator on 04/11/19 at 10:30am. 2. Review of Staff C's, supervisor, personnel record revealed: -There was no specific hire date documented in Staff C's record. -There was documentation of a TB skin test was administered on 06/18/15 and the TB result was read as negative on 06/20/15. -There were no other TB skin test results on record for Staff C. Interview with Staff C on 04/11/19 at 11:30am revealed: -She had been employed at the facility as a supervisor for four years. -She had not had any other TB skin test done since she started working at the facility or since the facility changed ownership in 09/18. Refer to interview with the Administrator on 04/11/19 at 10:30am. 3. Review of Staff D's, supervisor, personnel record on revealed: -There was no specific hire date documented in Staff D's record. -There was documentation of a TB skin test was administered on 12/10/16 and the TB result was read as negative on 12/12/16. -There were no other TB skin test results on record for Staff D. Attempted telephone interview with Staff D on	D 131		

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D 131	Continued From page 7 04/11/19 at 4:22pm was unsuccessful. Refer to interview with the Administrator on 04/11/19 at 10:30am. ________________ Interview with the Administrator on 04/11/19 at 10:30am revealed: -She "inherited" most of the staff who worked at the facility. -She did not know the staff were missing their TB skin tests because she thought all the staff records were in compliance from the previous owner and documentation of one previous negative TB skin test was sufficient for staff employed by the facility. -She was responsible for making sure the TB skin tests were completed upon hire for all staff. ______________ The facility failed to assure Staff A, Staff C, and Staff D were tested as required for tuberculosis which increased the risk of the transmission of disease. The facility's failure to assure staff were tested for TB was detrimental to the health, safety and welfare of the residents, which constitutes a Type B Violation. ______________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/15/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 26, 2019.	D 131		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall:	D 139		

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D 139	Continued From page 8	D 139		

(7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40;

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews and record reviews, the facility failed to complete a criminal background check on 1 of 4 sampled staff (Staff D).

The findings are:

Review of the facility's current license revealed the facility underwent a change of ownership effective 09/20/18.

Review of Staff D's, supervisor, personnel record on revealed:
-There was no specific hire date documented in Staff D's record.
-There was no documentation of a consent for a criminal background check for Staff D.
-There was no documentation that a criminal background check had been completed for Staff D.

Attempted telephone interview with Staff D on 04/11/19 at 4:22pm was unsuccessful.

Interview with the Administrator on 04/11/19 at 10:30am revealed:
-She inherited most of the staff who worked at the facility.
-She thought the old criminal background checks in the staff records were sufficient because the facility had only changed ownership and not staff.
-She did not know new criminal backgrounds were supposed to be done with the change of ownership
-She had not checked all of the staff records yet

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D 139	Continued From page 9 to verify if criminal backgrounds were needed. -She was responsible for making sure the criminal background checks were completed upon hire for all staff. ____________________ The facility failed to perform criminal background checks for 1 of 4 staff prior to hire which was detrimental to the 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 04/15/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 26, 2019.	D 139		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.	D 167		

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D 167	Continued From page 10	D 167		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record reviews and interviews, the facility failed to assure at least one staff person was left on the premises at all times who had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 1 of 4 sampled staff (Staff A) for 5 of 23 shifts.

The findings are:

Review of Staff A's personnel record revealed:
-Staff A's date of hire was documented as 01/28/19 as a medication aide/ supervisor.
-There was no documentation Staff A had completed CPR training within the last 24 months.

Review of the staffing schedule dated 03/18/19 through 03/31/19 revealed:
-There were three 8 hour shifts (7am-3pm, 3pm-11pm and 11pm-7am).
-Staff A, supervisor, worked first shift (7am -3pm) on 03/28/19, 03/20/19. 03/27/19, and 03/29/19 alone with no other staff at the facility.
-There was no staff scheduled to work with Staff A that had CPR training, within the last 24 months, on the dates listed above.

Observation on 04/09/19 revealed Staff A worked alone in the facility, without any other staff present, from 10:40am until 11:57am.

Interview with Staff A on 04/09/19 at 11:05am revealed:
-She had worked at the facility as a medication aide/supervisor (MA/S) for four months until recently.

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D 167	Continued From page 11 -Recently she had only been cooking and doing laundry at the facility because she had to complete some training. -She had to take her Cardio-Pulmonary Resuscitation (CPR) class. -She had not taken any CPR classes since her CPR certification expired in 2017 and she did not have a current CPR card. ______________________________ The facility failed to assure there was at least one staff person on duty at all times during first shift for 5 of 23 days from 03/18/19 through 04/08/19, who had completed a course on CPR and choking management, within the previous 24 months. The failure of not having adequately trained staff available in the event of cardiopulmonary arrest or choking was detrimental to the health, safety and welfare of the residents, which constitutes a Type B Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/09/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 26, 2019.	D 167		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including	D 234		

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D 234	Continued From page 12	D 234		

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, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 1 of 4 residents sampled (#2) were tested upon admission for tuberculosis (TB) disease.

The findings are:

Review of Resident #2's current FL-2 dated 03/04/19 revealed diagnoses included anxiety, neurologic bladder, suprapubic catheter, diabetes, hypertension, and hip pain.

Review of Resident #2's Resident Register revealed an admission date of 11/14/06.

Review of Resident #2's record revealed:
-There was documentation of one TB skin test placed on 06/20/14 and read as negative on 06/22/14.
-There was one TB skin test placed on 07/03/14, but no results on anticipated read date of 07/05/14 was documented.

Interview with Resident #2 on 04/11/19 at 4:30pm revealed she did not remember if her last TB skin test was read, but she did not think she had a positive TB skin test before.

Interview with the Administrator on 04/11/19 at 4:40pm revealed:
-She was responsible for verifying residents' TB skin test upon admission.

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D 234	Continued From page 13 -Resident #2 was admitted by the previous owners. -She did not know Resident #2's second TB skin test was not documented as being read. -She had not had a chance to go through each residents' record to check for TB skin tests.	D 234		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 4 sampled residents (#4) had an annual FL-2 that was signed by the primary care provider (PCP). The findings are: Review of Resident #4's most current FL-2 dated 02/01/18 revealed diagnoses included atrial fibrillation, coronary artery disease, hypertension, diabetes mellitus - type II, history of seizures, left sided hemiparesis, cerebral vascular infarction, history of heart catheterization, and deep vein thrombosis of the groin.	D 235		

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CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(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
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Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 04/15/16.

Review of Resident #4's most current care plan revealed it was dated 02/01/18.

Review of a summary visit note from Resident #4's PCP revealed Resident #4 was last seen by the PCP on 04/02/19/

Interview with the Administrator on 04/09/19 at 4:50pm revealed:
-She did not know Resident #4's FL-2 was outdated in her record.
-She thought she had Resident #4's new FL-2 in some paperwork in her office.
-She was responsible for making sure the residents' FL-2s were updated annually.

Second interview with the Administrator on 04/10/19 at 8:55am revealed:
-She had faxed Resident #4's updated FL-2 on 01/31/19 to Resident #4's physician for signature.
-Resident #4's physician never sent back the updated FL-2.
-She had meant to follow-up with Resident #4's physician about getting Resident #4's FL-2 signed but she forget to do it.

Telephone interview with a medical assistant with Resident #4's physician's office on 04/11/19 at 9:00am revealed she unable to find any record that Resident #4's updated FL-2 information had been faxed to Resident #4's physician's office on 01/31/19.

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 254	Continued From page 15	D 254		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 4 sampled residents (#4) had a care plan that was completed annually. The findings are: Review of Resident #4's most current FL-2 dated 02/01/18 revealed: -Diagnoses included atrial fibrillation, coronary artery disease, hypertension, diabetes mellitus -	D 254		

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D 254	Continued From page 16	D 254		

type II, history of seizures, left sided hemiparesis, cerebral vascular infarction, history of heart catheterization, and deep vein thrombosis of the groin.
-Resident #4 was intermittently disoriented and used a rollator for ambulation.
-Resident #4 required personal care assistance with bathing, dressing, and feeding.

Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 04/15/16.

Review of Resident #4's most current care plan dated 02/01/18 revealed:
-Resident #4 ambulated with an assistance device.
-She required limited assistance with bathing and dressing.
-She required extensive assistance with feeding.

Interview with the Administrator on 04/09/19 at 4:50pm revealed:
-She did not know Resident #4's care plan was outdated.
-She thought she had Resident #4's new care plan in some paperwork in her office.
-She was responsible for making sure the residents' care plans were updated annually.

Second interview with the Administrator on 04/10/19 at 8:55am revealed:
-She had faxed Resident #4's updated care plan on 01/31/19 to Resident #4's physician for signature.
-Resident #4's physician never sent back the updated care plan.
-She had meant to follow-up with Resident #4's physician about getting Resident #4's care plan signed but she forget to do it.

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 254	Continued From page 17 Telephone interview with a medical assistant with Resident #4's physician's office on 04/11/19 at 9:00am revealed she unable to find any record that Resident #4's updated care plan information had been faxed to Resident #4's physician's office on 01/31/19.	D 254		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure staff provided personal care assistance for 1 of 4 sampled residents (#2) regarding a resident not receiving suprapubic catheter care and had a fall trying to preform own catheter care. The findings are: Review of Resident #2's current FL-2 dated 03/04/19 revealed diagnoses included anxiety, neurologic bladder, suprapubic catheter, diabetes, hypertension, and hip pain.	D 269		

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 269	Continued From page 18 Review of Resident #2's care plan dated 03/11/19 revealed: -Resident #2 had a history of mental health illness. -Resident #2 had range of motion and limited strength in his upper extremities (bilateral). -Resident #2 had a suprapubic catheter with no instruction for self-care. -Resident #2 required extensive assistance with toileting (change bags in am/pm monitor for problems). Review of a Licensed Health Professional Support (LHPS) evaluation dated 02/21/19 revealed: -Resident #2 had a suprapubic catheter that was followed up by a home health agency. -The staff LHPS competency validated in catheter care read "see personnel file". -Catheter care for Resident #2 included suprapubic catheter drainage bag changing. Review of an Accident/Incident report dated 03/25/19 revealed: -Resident #2 "was in the bathroom emptying her urine bag and slid down to her bottom, her feet just slid right out from under her". -Resident #2 was sent to the hospital and was "cleared". -Resident #2 and staff was instructed that staff was to change the catheter bags. Interview with Resident #2 on 04/11/19 at 4:30pm revealed: -She had a suprapubic catheter. -She changed her urine collection bag twice a day. -Staff only helped depending on who was working.	D 269		

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 269	Continued From page 19 -She had a fall attempting to empty her catheter bag. Interview with the Home Health Nurse (HHN) on 04/10/19 at 8:38am revealed: -Resident #2 was being followed by HH for suprapubic catheter care. -HHN saw Resident #2 monthly and was responsible for changing the resident's suprapubic catheter monthly. Telephone interview with Resident #2's Primary Care Provider (PCP) on 04/10/19 at 1:47pm revealed HH was to change the suprapubic catheter and the staff at the facility was to perform daily catheter care including changing the catheter bag. Interview with a medication aide/supervisor (MA/S) on 04/09/19 at 11:05am revealed: -The drainage bag in the common bath room belonged to Resident #2. -Resident #2 did her own catheter care. -Resident #2 changed the catheter bag in the morning and at night. -She did not change Resident #2's catheter bag. Interview with a second MA/S on 04/10/19 at 11:05am revealed: -Resident #2 changed her own catheter bag. -She would sometimes help Resident #2 change her catheter bag, but the resident could change it on own her own. Interview with the Administrator on 04/11/19 at 8:30am revealed: -Resident #2's catheter bag was to be changed in the am and pm. -Staff was responsible for changing Resident #2's catheter bag.	D 269		

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D 269	Continued From page 20 -Resident #2 had fallen attempting to empty her catheter bag on 03/25/19. -Resident #2 and staff had been informed that staff was to change the resident's catheter bag after Resident #2 fell on 03/25/19.	D 269		
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 physician notification for 1 of 4 sampled residents (#1) (Resident #1) with elevated blood pressures (BP). The findings are: Review of Resident #1's current FL-2 dated 06/01/18 revealed diagnoses included bipolar, coronary artery disease (CAD) and hypothyroidism. Review of Resident #1's physician's order dated 06/20/18 revealed an order to check BP daily with parameters of systolic BP greater than 180 or less than 100 and diastolic BP greater than 100 o or less than 50 call the Primary Care Provider (PCP).	D 273		

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D 273	Continued From page 21	D 273		

Review of Resident #1's vital sign sheets for February, March and April 2019 revealed there were six days of BP outside of the ordered parameters, DBP ranging from 100 to 106.

Review of Resident #1's record revealed there was no documentation of a Resident #1's PCP being notified of 6 BPs outside of the parameters.

Attempted telephone interview with Resident #1's PCP on 04/11/19 at 11:33am was unsuccessful.

Interview with a medication aide (MA) on 04/11/19 at 7:00pm revealed:
-The staff (MAs) were supposed to call the Administrator if the PCP needed to be contacted about a resident.
-The MA's did not call the residents' PCP.

Interview with the Resident Care Coordinator (RCC) on 04/11/19 at 5:50pm revealed the staff were supposed to call the Administrator if the resident's BP was outside of the parameters.

Interview with the Administrator on 04/11/19 at 10:00am revealed:
-The MA/S was to record the vital signs on the facility's vital sign sheet.
-The MA/S was to notify her if the resident's BP were not with in the physician ordered parameters.
-She did not know Resident #1's BP had been outside of the parameters for 6 days.
-No staff had notified her of Resident #1's BPs outside of the parameters.
-She had not notified Resident #1's PCP of the BPs outside of the set parameters.

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D 276	Continued From page 22	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to implement physician orders for 1 of 4 sampled residents (#2) with orders for urine laboratory (lab) tests. The findings are: Review of Resident #2's current FL-2 dated 03/04/19 revealed diagnoses included anxiety, neurologic bladder, suprapubic catheter, diabetes, hypertension, and hip pain. Review of Resident's #2's physician's order dated 03/25/19 revealed an order for the collection of a urine specimen from the resident for UA (urinalysis to diagnose urinary tract infection (UTI)) to rule out a UTI. Review of Resident #2's record revealed there was no documentation of Resident #2's UA being	D 276		

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 276	Continued From page 23 collected or lab results. Interview with Resident #2 on 04/11/19 at 4:30pm revealed: -She had a suprapubic catheter. -She changed her urine collection bag twice a day. -She had not had any lab work done on her urine that she knew of in the last 3 months. Interview with the Resident Care Coordinator (RCC) on 04/11/19 at 5:50pm revealed: -She did not know Resident #2 had an order for a UA on 03/25/19. -She had not collected a UA for Resident #2. -The UA collection kits where kept at the facility to be used when a resident had an order for a UA. -The Administrator was responsible for reviewing the physician's orders. Interview with the Administrator on 04/11/19 at 4:25pm revealed: -She did not know Resident #2 had an order for a UA on 03/25/19. -Resident #2 had not had the UA done. -She was responsible for checking physician's orders. -She did not see the order for the UA when she reviewed the physician's order.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.	D 282		

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 282	Continued From page 24 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure foods being stored and served to residents were protected from contamination related to a build-up of food debris and spillage in the freezer. The findings are: Interview with the medication aide/supervisor (MA/S) on 04/09/19 at 2:12pm revealed only the Administrator and another staff who stocked food in the facility had a key to the freezer. Observations of the freezer on 04/09/19 between 12:30pm and 12:35pm revealed: -There was a dark brownish-black color along the door casing and inner rubber seal. -Three bags of different varieties of bagged breads were stored on the bottom shelf of the freezer -The bottom shelf of the freezer was covered with a yellowish, brownish, pinkish flaky looking substance. -The rubber seal along the bottom of the freezer was stained with a brownish colored substance in multiple places and the middle portion of the rubber seal was detached from the freezer door. -There were brownish colored drippings along the inside freezer walls and door. Interview with the Administrator on 04/11/19 at 12:32pm revealed: -The freezer remained locked with a padlock and only herself and the food purchase staff (FPS) had access to the key. -She did not know what was in the bottom of the freezer. -The freezer was used to store bread.	D 282		

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 282	Continued From page 25 -She did not know what else was stored in the freezer. -The third shift staff duties included cleaning the refrigerator and freezer. -She thought the freezer was being cleaned by third shift staff. -It had not occurred to her that third shift staff did not have a key to unlock the freezer to clean inside. -Normally the FPS stored food in the freezer. Interview with the FPS on 04/11/19 at 12:30pm revealed: -She only stored bread in the freezer. -She did not know what the spilled substance in the bottom of the freezer was, but thought it was food spillage. -She went in the freezer at least every other day. -She did not know how long the spillage in the bottom of the freezer had been there. -She did not recall telling the Administrator about the spillage in the freezer. -The third shift staff were responsible for cleaning the freezer. -She was not responsible for cleaning the freezer. Review of the first, second, and third shift duties posted in the kitchen revealed on every Wednesday, third shift staff was supposed to clean out the freezer.	D 282		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to assure that nutritional supplements were served as ordered to 1 of 2 residents sampled (#4).

The findings are:

1 Review of Resident #4's FL-2 dated 02/01/18 revealed:
-Diagnoses included atrial fibrillation, coronary artery disease, hypertension, diabetes mellitus - type II, history of seizures, left sided hemiparesis, cerebral vascular infarction, history of heart catheterization, and deep vein thrombosis of the groin.

Review of a physician's office visit summary for Resident #4 dated 01/25/19 revealed there was an order for a diabetic nutritional supplement to be administered one can with each meal.

Observation of Resident #4's lunch meal on 04/09/19 from 12:00pm through 12:35pm revealed she did not receive a nutritional supplement with her meal.

Observation of non-diabetic nutritional supplement supply on 04/10/19 at 10:30am revealed there was no supply of non-diabetic nutritional supplement available in the facility.

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Review of March 2019 Medication Administration Record (MAR) for Resident #4 revealed:
-There was an entry for the administration of a non-diabetic nutritional supplement one can with each meal, three times daily at 8:00am, 12:00pm and 5:00pm.
-Metformin 500mg was not documented as administered once daily with dinner on 03/01/19, 03/02/19, 03/03/19, 03/04/19, 03/05/19, 03/06/19, and 03/07/19.
-The non-diabetic nutritional supplement was documented as administered, one can with each meal instead of the diabetic nutritional supplement scheduled for 8:00am, 12:00pm and 5:00pm.
-There were four documented administrations out of ninety-three opportunities for March 2019.
Review of April 2019 Medication Administration Record (MAR) for Resident #4 revealed:
-There was an entry for the administration of a non-diabetic nutritional supplement one can with each meal, three times daily at 8:00am, 12:00pm and 5:00pm.
-A non-diabetic nutritional supplement was documented as administered, one can with each meal instead of the diabetic nutritional supplement scheduled for 8:00am, 12:00pm and 5:00pm.
-There was no documentation of administration at 8:00am 12:00pm and 5:00pm from 04/01/19 through 04/10/19.

Interview with Resident #4 on 04/10/19 at 10:25am revealed:
-The MA/S asked her daily if she wanted her supplement for that day.
-The facility used to provide the supplement that she liked and she would drink them.
-The facility changed the supplement about 3

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D 310	Continued From page 28	D 310		

weeks ago.
-She did not like the current supplement provided by the facility so she would not drink them.
-The Administrator knew that she did not like the new supplements and that was why she had not been drinking them.

Interview with a medication aide/supervisor (MA/S) on 04/10/19 at 10:20am revealed:
-The MA/S were responsible for administering the supplements.
-The MA/S were responsible for documenting the administration of the supplements on the MAR.
-The supplement offered was an instant breakfast mix.
-She had offered the supplements to Resident #4 and she refused.
-She did not know why Resident #4 refused the supplement.
-She had not asked the resident why she had refused the supplements.

Interview with The Administrator on 04/10/19 at 10:40am revealed:
-She knew Resident #4 had been refusing the supplements.
-She had not thought of any other options to address the issue of the resident not drinking the supplement.
-The facility provided the supplement for the residents.
-The only supplement the facility provided was a non-diabetic nutritional supplement instant breakfast mix.
-She had not informed Resident #4's primary care provider regarding not offering the resident a non-diabetic nutritional supplement as ordered and only offering an alternate supplement.

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D 315	10A NCAC 13F .0905(a)(b) Activities Program	D 315		

10A NCAC 13F .0905 Activities Program
(a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.
(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to develop and implement an activity program that promoted active involvement for all 10 residents who resided in the facility.

The findings are:

Observation on 04/09/19 at 1:00pm revealed there was no activity calendar posted in the facility.

Interview with a resident on 04/09/19 at 10:59am revealed:
-There were no activities, no games, and no offers to go out.
-She mainly did activities through her church.
-"We pretty much do nothing except watch TV and smoked cigarettes."

Interview with a second resident on 04/09/19 at 4:15pm revealed:
-There were no activities and the residents only watched TV.
-There were no outings offered at the facility for

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the residents.

Observation on 04/09/19 from 9:45am - 2:55pm and 3:55pm - 5:35pm at various times revealed no activities were offered by staff or done by any residents at the facility.

Observation on 04/11/18 from 8:20am - 2:55pm and 3:55pm - 8:55pm at various times revealed no activities were offered by staff or done by any residents at the facility.

Interview with a third resident on 04/11/19 at 4:30pm revealed:
-There were few activities offered at the facility.
-She mostly watched TV.

Interview with a fourth resident on 04/10/19 at 12:00pm revealed the facility never took the residents anywhere.

Interview with a medication aide/supervisor (MA/S) on 04/10/19 at 8:40am revealed:
-"We do activities if we (staff) have the time."
-There was an activities person that sometimes came to the facility.
-Most of the time the residents just watched TV.

Interview with the Administrator on 04/11/19 at 8:30am revealed:
-There was no activity calendar for the facility.
-She was supposed to make up an activity calendar for the facility, but she had not had time to make the calendar.
-The facility did have an Activity Director (AD) who did some activities with the residents, but fourteen hours of activities a week was not offered to the residents at the facility.
-She had not had time to plan for the activities with the AD.

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D 315	Continued From page 31 -She and the staff did take the residents on outings using their own personal cars. -The residents went out on outings at least every other month.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure residents were treated with respect and dignity and resided in an environment free of verbal abuse. The findings are: 1. Based on observations and interviews, the facility failed to assure all residents were treated with dignity and respect as evidenced by verbal abuse by two direct care staff that included a supervisor and the RCC, the Resident Care Coordinator (RCC) [Refer to Tag 911 G.S. 131D-21(1) (Type B Violation)].	D 338		

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D 358	Continued From page 32	D 358		
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: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 2 of 4 sampled residents (#1 and #4) which included a delay in starting pain medication, blood pressure medication, and an inhaler (#1); an diabetes medication (#4). The findings are: 1. Review of Resident #1's current FL-2 dated 06/01/18 revealed there was diagnoses included bipolar, coronary artery disease (CAD) and hypothyroidism. a.Review of Resident #1's physician's orders dated 04/04/19 revealed there was a medication	D 358		

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order for Naproxen 500mg take twice daily with food (used to treat pain).

Review of Resident #1's April 2019 Medication Administration Record (MAR) revealed there was documentation of administration for Naproxen 500mg being first given at 5:00pm on 04/08/19.

Observation of Resident #1's medications on hand on 04/11/19 revealed Naproxen 500mg was available and dispensed sixty tablets on 04/05/19 with fifty-three tablets on hand.

b.Review of Resident #1's physician's orders dated 04/04/19 revealed there was a medication order for Trelegy at hour of sleep (used to prevent and control wheezing and shortness of breath).

Review of Resident #1's April 2019 Medication Administration Record (MAR) revealed there was documentation of administration for Trelegy at bedtime on 04/08/19.

Observation of Resident #1's medications on hand on 04/11/19 revealed Trelegy Ellipta 100-62.5-25 was available and dispensed on 04/08/19.

c.Review of Resident #1's physician's orders dated 04/04/19 revealed there was a medication order for Micardis 20mg take every day (used to treat high blood pressure).

Review of Resident #1's April 2019 Medication Administration Record (MAR) revealed there was no documentation of administration for Micardis 20mg daily for 04/04/19 through 04/10/19.

Observation of Resident #1's medications on hand on 04/11/19 revealed Micardis 20mg was

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available and dispensed thirty tablets on 04/09/19 with twenty-nine on hand.

Interview with a medication aide/supervisor (MA/S) on 04/11/19 at 7:00pm revealed the Resident Care Coordinator (RCC) and the administrator were responsible for ordering and reordering medications.

Interview with the Resident Care Coordinator (RCC) on 04/11/19 at 5:50pm revealed:
-She was responsible for reordering medications.
-The Administrator was responsible for reviewing and ordering new medications.
-She would send the new medication order or the Primary Care Provider (PCP) would send the request to the pharmacy and the pharmacy would send the medication no later than the next day it the medication is something the pharmacy has.

Interview with the Administrator on 04/11/19 at 10:00am revealed:
-She was responsible for reviewing new orders and ordering new medications from the pharmacy.
-Resident #1 had received new medication orders from the PCP on 04/04/19.
-The medications did not arrive from the pharmacy until 04/08/19.
-Resident#1 did not receive the new medications until 04/08/19.
-She had called the pharmacy on 04/08/19 to see why the medication had not been delivered.
-She was told by the pharmacy that the doctor had not sent the prescription in to the pharmacy.

Attempted telephone interview with a representative of the facility's pharmacy on 04/11/19 at 9:58am was unsuccessful.

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Attempted telephone interview with Resident #1's PCP on 04/11/19 at 11:32am was unsuccessful.

2. Review of Resident #4's most current FL-2 dated 02/01/18 revealed diagnoses included diabetes mellitus - type II.

Review of a primary care provider's medication order for Resident #4 dated 01/30/19 revealed a medication order for Metformin 500mg daily with dinner (Metformin is a medication used to lower blood sugar).

Review of Resident #4's March 2019 Medication Administration Record (MAR) revealed:
-There was an handwritten entry for the administratrion of Metformin 500mg once daily in the evening.
-Metformin 500mg was not documented as administered once daily with dinner on 03/01/19, 03/02/19, 03/03/19, 03/04/19, 03/05/19, 03/06/19, and 03/07/19.

Review of Resident #4's March 2019 vital sign sheets revealed Resident #4's blood sugar readings ranged from 189 to 287.

Interview with a supervisor/medication aide on 04/10/19 at 11:20am revealed:
-She did not know why Resident #4 had seven missed doses of Metformin in March 2019.
-There may have been a problem with getting Resident #4's medication from the pharmacy.
-The Administrator handled it if there were any problems with getting medications from the pharmacy.
-If a resident's medication was not on the medication cart then staff documented the medication was not administered on the MAR and told the Administrator that a medication was

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missing.

Attempted telephone interview with the facility's pharmacy on 04/11/19 at 8:59am at 11:59am were unsuccessful.

Telephone interview with a medical assistant with Resident #4's primary care provider's (PCP) office on 04/11/19 at 9:00am revealed:
-The PCP was did not know Resident #4 had missed seven doses of Metformin in March 2019.
-The facility had not notified their office of the missed doses of Metformin.
-The PCP expected Resident #4 to receive all of her medications as ordered and for the facility to call if there was a problem with administering the medication no later than 3 days after the problem occurred.
-Missed doses of Metformin could cause Resident #4's blood sugar readings to be elevated.

Interview with the Resident Care Coordinator (RCC) on 04/11/19 at 10:20am revealed:
-She did not know Resident #4 had missed doses of Metformin.
-The Administrator was responsible to follow-up with the pharmacy or the PCP if there were problems with getting medications from the pharmacy.

Interview with the Administrator on 04/11/19 at 1:15pm revealed:
-Resident #4 missed seven doses of Metformin in March 2019 because there was a problem with the medication order and the pharmacy.
-The pharmacy would not send Resident #4's Metformin because the pharmacy reported they could not locate the medication order for Resident #4's Metformin.

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D 358	Continued From page 37 -There was a medication order in Resident #4's record for Metformin that was written in January 2019. -The order was sent to the pharmacy in January 2019.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by:	D 367		

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Based on observations, record reviews and interviews, the facility failed to assure the medication administration records were accurate 1 of 4 sampled residents (#2).

The findings are:

Review of Resident #2's current FL-2 dated 03/04/19 revealed diagnoses included anxiety, neurologic bladder, suprapubic catheter, diabetes, hypertension, and hip pain.

Review of Resident #2's physician's orders dated 02/04/19 revealed there was a medication order for Metformin ER 500 mg daily (used to treat hyperglycemia).

Observation of Resident #2's medications on hand on 04/11/19 revealed Metformin ER 500mg take one tablet two times daily with meals morning and evening was available with sixty dispensed on 04/01/19 with twenty-seven on hand.

Review of Resident #2's March 2019 Medication Administration Record (MAR) revealed:
-There was an entry for Metformin ER 500mg take one tablet twice daily with meals, scheduled for 8:00am and 5:00pm.
-There was no documentation of administration for Metformin ER 500mg from 03/01/19 through 03/31/19.

Review of Resident #2's April 2019 MAR revealed:
-There was an entry for Metformin ER 500mg take one tablet twice daily with meals, scheduled for 8:00am and 5:00pm.
-There was no documentation of administration for Metformin ER 500mg from 04/01/19 through

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D 367	Continued From page 39 04/11/19. Interview with a medication aide/supervisor (MA/S) on 04/11/19 at 7:00pm revealed: -She did not give Resident #2 the Metformin at night. -She did know that the MAR said the resident is supposed to get the medication twice per day. -She did not follow the directions on the MAR because of the note placed on the MAR by the Administrator said to only give the medication in the morning and not to sign. -She did not indicate on the MAR not giving the resident the medication by circling her initials, "I don't put anything". -She knew that she was supposed to indicate on the MAR if a resident did not get the medications and why. -The note had been on Resident #2's MAR for at least 2 months. Interview with the Administrator on 04/11/19 at 2:15pm revealed: -She told the staff to not document the administration of Resident #2's Metformin ER on her medication administration record (MAR). -There was a conflict between the pharmacist and the Resident #2's primary care provider regarding the correct dosage that printed on the Resident #2's MAR. -The primary care provider had written an order that changed Resident #2's Metformin ER from twice a day to once a day. -The pharmacist did not agree with change in the physician's order and would not change the medication order on Resident #2's MAR. -She told the staff not to document Resident #2's Metformin ER administration at all on the MAR because she was trying to avoid any conflicts in documentation of the new Resident #2's	D 367		

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D 367	Continued From page 40 Metformin ER order and the pharmacy refusal to change the order on the MAR. Attempted telephone interview with Resident #2's PCP on 04/11/19 at 12:00pm was unsuccessful. Attempted telephone call to the pharmacy on 04/11/19 at 9:58am was unsuccessful.	D 367		
D 372	10A NCAC 13F .1004 (o) Medication Administration 10A NCAC 13F .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medications were not borrowed affecting at least 1 of 4 sampled residents (Resident #4). The findings are: Review of Resident #4's most current FL-2 dated 02/01/18 revealed diagnoses included atrial fibrillation, coronary artery disease, and deep vein thrombosis of the groin. Review of Resident #4's physician's orders dated 05/21/18 revealed a medication order for	D 372		

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polyethylene glycol mix 1 capful (17gm) in 8 ounces of water or juice once daily in the morning (Polyethylene glycol is a medication used to treat constipation).

Observation of the Resident's #4's medications on hand on 04/11/19 at 11:38am revealed:
-There was a bottle labeled polyethylene glycol identified as a medication used for Resident #4.
-The bottle of polyethylene glycol was approximately half full.
-The prescribing information including a resident's name and dosage information for polyethylene glycol had been redacted.
-There was a second label with only another resident's name who resided in another facility and no administration directions.
-The dispensing date for the bottle of polyethylene glycol was 06/04/18 and the expiration date was March 2021.

Review of the pharmacy dispensing records for Resident #4 revealed polyethylene glycol was dispensed on 07/19/18, 07/30/18, 09/06/18, 12/02/18, 12/25/18, 01/30/19, 02/22/19, and 03/26/19.

Review of Resident #4's February 2019 medication administration record (MAR) revealed:
-There was a computer generated entry for polyethylene glycol mix 1 capful with eight ounces of water or juice once daily in the morning.
-Polyethylene glycol was documented as administered at 8:00am from 02/01/19 through 02/28/19.

Review of Resident #4's March 2019 MAR revealed:
-There was a computer generated entry for polyethylene glycol mix 1 capful with eight ounces

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of water or juice once daily in the morning.
-Polyethylene glycol was documented as administered at 8:00am from 03/01/19 through 03/31/19.

Review of Resident #4's April 2019 MAR revealed:
-There was a computer generated entry for polyethylene glycol mix 1 capful with eight ounces of water or juice once daily in the morning.
-Polyethylene glycol was documented as administered at 8:00am from 04/01/19 through 04/10/19.

Attempted review of the facility's medication policies on 04/09/19 at 4:50pm revealed the medication policies were requested but not provided by the facility.

Interview with a medication aide/supervisor on 04/11/19 at 11:40am revealed:
-She did not know whose bottle of polyethylene glycol was in Resident's #4 medications.
-That was the only bottle of polyethylene glycol used by the staff to administer to Resident #4.
-She had used from the bottle of polyethylene glycol for Resident #4 for the last 3 or 4 weeks because it was what she was told to do during report.
-She could not remember who instructed her to use the bottle of polyethylene glycol.
-She did not know the medication belonged to another resident because she did not see the label on the side of the bottle.
-She did not know if Resident #4 had her own bottle of polyethylene glycol.
-The Resident Care Coordinator (RCC) or the Administrator brought the medications to the medication cart and ordered all of the medications for the residents used on the

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medication cart.
-She did not know if the facility had any medication policies in place regarding the borrowing of resident's medication for use with other residents.

Confidential staff interview revealed:
-Staff had been using the other resident's bottle of polyethylene glycol for Resident #4 for at least a month because that was what the Administrator and the RCC instructed.
-Staff did not know why the staff was instructed to administer another resident's medication to Resident #4 by the Administrator and the RCC.
-Staff had complained to the RCC about using the other resident's polyethylene glycol for Resident #4 and the RCC redacted the prescription label to conceal the other resident's name and dosage information.
-The staff did not know why this was done.
-Staff could not recall if the bottle of polyethylene glycol had the name of the other resident on a sticker on the side.
-Staff did not know if the facility had any medication policies in place regarding the borrowing or using of resident's medication for use with other residents.
-The RCC and the Administrator were responsible for checking in the medications on the medication cart and ordering all medications for the residents.

Interview with the RCC on 04/11/19 at 11:45am revealed:
-She did not know staff were using another resident's polyethylene glycol for Resident #4.
-She did not know why staff were using another resident's polyethylene glycol for Resident #4.
-She did not know how the other resident's polyethylene glycol got into the medication cart for

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D 372	Continued From page 44 Resident #4. -She had not told any staff to use the other resident's polyethylene glycol for Resident #4. -The Administrator was responsible for ordering the residents' medications and putting them on the medication cart. -She expected staff to administer each resident their own medications. -She did not know if the facility had any medication policies in place regarding borrowing or using resident's medications for other resident's use. Interview with the Administrator on 04/11/19 at 11:50am revealed: -She had put the other resident's polyethylene glycol on the medication cart and told the staff to use it for Resident #4 about two or three weeks ago. -She was trying to save Resident #4 money by using leftover medication from another resident who resided in another facility. -She told the staff to use leftover medications from other residents because she thought she "was helping the residents". -Resident #4 had her own bottle of polyethylene glycol but she had told the staff to use the leftover medications first. Attempted telephone interview with the facility's pharmacy on 04/11/19 at 11:59am was unsuccessful. Second interview with the Administrator on 04/11/19 at 1:15pm revealed: -She had Resident #4's bottle of polyethylene glycol in her office. -She had removed it from the medication cart about two or three weeks ago and replaced it with the other resident's bottle polyethylene glycol.	D 372		

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D 372	Continued From page 45 -Resident #4's polyethylene glycol was last been dispensed from the pharmacy on 02/22/19 and not 03/26/19. Observation of Resident #4's medications on 04/11/19 at 12:15pm revealed there was an unopened bottle of polyethylene glycol from the facility's pharmacy labeled for Resident #4 that was dispensed 02/22/19.	D 372		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure medication orders for a topical analgesic and self-administration of medication ordered for 2 of 4 sampled residents (#1 and #2) were maintained in the residents' records. The findings are:	D 375		

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Review of Resident #1's current FL-2 dated 06/01/18 revealed diagnoses included bipolar, coronary artery disease (CAD) and hypothyroidism.

Observation of Resident #1's room on 04/09/19 at 11:24am revealed there was a 16 ounce bottle of arthritis and sport rub on the resident's dresser.

Review of Resident #1's medication orders revealed there were no medication orders for arthritis and sport rub, and no order for self-administration.

Interview with Resident #1 on 2/6/18 at 11:25am revealed:
-She used the arthritis rub for her knees when she needed it.
-The medication was an over the counter medication that she had purchased.
-Her doctor had not ordered it for her.
-She applied the medication to her knees when she need to.
-She did not know if the Administrator or staff knew she had the medication.
-She did not think her doctor knew she was using the medication.

Interview with the Administrator on 04/09/19 at 4:50pm revealed:
-She did not know Resident #1 had the arthritis and sport rub in her room.
-Residents may keep medications at bedside with a physician order.
-Resident #1 did not have an order or a self-administration order for the medication.
-The facility did not have written policies and procedures for medication kept at bedside or self-administration of medications.

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-She was currently working on the medication polices.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/11/19 at 11:33am was unsuccessful.

2. Review of Resident #4's most current FL-2 dated 02/01/18 revealed diagnoses included atrial fibrillation, coronary artery disease, hypertension, diabetes mellitus - type II, history of seizures, left sided hemiparesis, cerebral vascular infarction, history of heart catheterization, and deep vein thrombosis of the groin.

Review of Resident #4's standing orders dated 05/21/18 revealed an order for Neosporin Ointment (used to treat and prevent minor skin infections) to be applied to skin tears and cover with a non-stick dry dressing daily.

Review of Resident #4's record revealed there were no orders for Neosporin to be kept at bedside and no self-administration order.

Observation of medications in Resident #4's room on 04/10/19 at 12:00pm revealed:
-There was a 0.5 ounce tube of Neosporin antibiotic ointment sitting on top of the resident's night stand that was over half used.
-Resident #4 had a roommate that was present in the room.

Interview with Resident #4 on 04/10/19 at 12:00pm revealed:
-The Neosporin ointment belonged to her.
-She applied the ointment to hair bumps on her legs as needed.
-Her doctor did not know she was using the Neosporin ointment for her hair bumps.

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D 375	Continued From page 48 -The ointment was usually stored on her night stand. -Another resident had brought the ointment from the store for her to use. -She had last used the ointment on 04/09/19. -She applies the ointment herself. Interview with the Administrator on 04/09/19 at 4:50pm revealed: -She did not know Resident #4 had the Neosporin ointment in her room. -She knew all the medications kept at beside had to be secured. -Residents had to have a may keep at bedside order from the Primary Care Provider (PCP) in order to keep medications at bedside. -Resident #4 did not have a may keep at bedside order or a self-administration order for the medication. -She thought a may keep at bedside order was the same as a self-administration order. -The facility did not have written policies and procedures for medication kept at bedside or self-administration of medications. -She was currently working on the medication polices.	D 375		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10a NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration	D 378		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to assure medications were maintained in a safe manner under locked security or direct supervision of staff in charge of medication administration for one mini-refrigerator located in an unsecured space in the facility's main hallway that was used for the storage of insulin and eye drops and was accessible to all residents in the facility.

The findings are:

Observation of the facility's main hallway on 04/09/19 at 1:05pm revealed:
-There was a mini refrigerator was located in the hallway adjacent to the left side of the Administrator's office.
-The mini-refrigerator was unsecured with no locking mechanism and was accessible to all of the residents in the facility.
-There was an unlabeled Lantus insulin pen on the top shelf of the inside door (Lantus is a medication used to treat diabetes).
-There were two unopened boxes of Levemir Flextouch that contained fifteen insulin pens each on the top shelf of the refrigerator (Levemir is a medication used to lower blood sugar).
-There was an unopened box of Lantus insulin that contained fiften insulin pens on the top shelf of the refrigerator (Lantus is a medication used to lower blood sugar).
-There was an opened box of Levemir that contained one insulin pen on the top shelf of the refrigerator (Levemir is a medications used to treat lower blood sugar).
-There were two partial used Novolog insulin pens on the top shelf of the refrigerator (Novolog

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is a medications used to treat lower blood sugar).
-There was an unopened box of Humalog that contained one insulin pen on the bottom shelf of the refrigerator (Humalog is a medication used to lower blood sugar).
-There were two unopened boxes of Lantus that contained one insulin pen each on the bottom shelf of the refrigerator (Lantus is a medication used to lower blood sugar).
-There was an unopened box of Novolog that contained fifteen insulin pens on the bottom shelf of the refrigerator (Novolog is a medication used to lower blood sugar).
-There was an unopened box of Levemir Flextouch that contained fifteen insulin pens on the bottom shelf of the refrigerator (Levemir is a medication used to lower blood sugar).
-There was an unopened box of Tresiba insulin that contained fifteen insulin pens on the bottom shelf of the refrigerator (Tresiba is a medication used to lower blood sugar).
-There were two unopened boxes of Latanoprost eye drops on the bottom shelf of the refrigerator (Latanoprost are eye drops used to treat glaucoma).

Interview with a supervisor/medication aide on 04/09/19 at 1:10pm revealed:
-This was the medication refrigerator used to store the residents' medications that required refrigeration.
-The refrigerator never had a lock and the medications inside the refrigerator were never secured.
-The refrigerator had been unlocked and positioned in the hallway adjacent the Administrator's door for several years.

Interview with the Resident Care Coordinator (RCC) at 04/09/19 at 1:15pm revealed:

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D 378	Continued From page 51 -The mini-refrigerator was located in the main hallway of the facility at least since she started working at the facility last May 2018. -The mini-refrigerator had never been locked and was accessible to all of the residents. -All of the medications that required refrigeration were kept inside the mini-refrigerator. -There had not been any problems with any residents attempting to go inside the mini-refrigerator. Interview with the Administrator on 04/09/19 at 4:25pm revealed: -The mini-refrigerator was always located in the hallway on the left side of her office since she started working at the facility last May 2018. -The mini-refrigerator was used to store the residents' medications that required refrigeration. -She had never considered the medications inside of the mini-refrigerator needed to be locked up because no one had ever mentioned it to her. -She did not know of any problems with residents going inside the mini-refrigerator or attempting to remove any medications from the mini-refrigerator.	D 378		
D 379	10a NCAC 13F .1006 (c) Medication Storage 10a NCAC 13F .1006 Medication Storage (c) The medication storage area shall be clean, well-lighted, well-ventilated, large enough to store medications in an orderly manner, and located in areas other than the bathroom, kitchen or utility room. Medication carts shall be clean and medications shall be stored in an orderly manner.	D 379		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to assure a medication mini-refrigerator was kept clean as evidenced by black stains along the bottom and left wall of the refrigerator and approximately three inches of ice that encased the bottom of the freezer compartment that located on directly over a shelf that contained several insulin pens.

The findings are:

Observation of the facility's main hallway on 04/09/19 at 1:05pm revealed:
-There was a mini refrigerator located in the hallway adjacent to the left side of the Administrator's office.
-There were scattered black stains along the bottom of the inside of the refrigerator and the left wall of the refrigerator.
-There was a slab of ice approximately three inches thick that encased the bottom of the freezer compartment.
-There were two unopened boxes of Levemir Flextouch pens that contained fifteen insulin pens, an unopened box of Lantus that contained fifteen insulin pens, two partial used Novolog insulin pens, and an opened box of Levemir that contained one insulin pen on the top shelf of the mini- refrigerator located directly below the slab of ice. (Levemir, Lantus, and Novolog are medications used to treat lower blood sugar).

Interview with a supervisor/medication aide on 04/09/19 at 1:10pm revealed:
-She had not noticed the black stains or the ice build-up inside the mini refrigerator.
-She did not know when the mini-refrigerator used to store residents' medications was last cleaned.

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D 379	Continued From page 53 -The medication aides were not responsible for cleaning the mini-refrigerator. -She did not know who was responsible for cleaning the refrigerator. Interview with the Resident Care Coordinator (RCC) at 04/09/19 at 1:15pm revealed: -She had not noticed the black stains or ice buildup inside the mini-refrigerator. -She was not sure when the mini-refrigerator was last cleaned or who was responsible for cleaning the refrigerator. Interview with the Administrator on 04/09/19 at 4:25pm revealed: -She was responsible for cleaning the mini-refrigerator that contained the residents' medications. -She was not sure when the mini-refrigerator was last cleaned. -She has not noticed the black stains or ice buildup inside of the mini-refrigerator. -None of the staff had told her the refrigerator needed to defrosting or cleaning. -She was not sure how often she checked mini-refrigerator to see if it was clean.	D 379		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: TYPE B VIOLATION	D911		

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Based on observations and interviews, the facility failed to assure all residents were treated with dignity and respect as evidenced by verbal abuse by two direct care staff that included a supervisor and the RCC, the Resident Care Coordinator (RCC).

The findings are:

1. Observation on 04/09/19 at 1:50pm revealed:
-The RCC was in the dining room at the medication cart with another staff and three residents.
-The RCC was overheard yelling at a resident in the dining room "Don't you see I am doing something! You are just going to have to wait!".
-The RCC was overheard yelling by the survey team through the closed door of the residents' dayroom that was located directly across the hall from the dining room.

Interview with a resident on 04/09/19 at 4:00pm revealed:
-The RCC yelled at her today because she had asked for her scheduled 2:00pm medications early.
-The RCC yelled that she was going to have to wait for her medication because it was not time for the medication to be given.
-The RCC had yelled at her several times but she could not be specific when or how many times the RCC had yelled at her.
-She did not like being yelled at by the RCC but she had not complained to the Administrator because when she got tired of it; she yelled back at the RCC.

Interview with a supervisor on 04/09/19 at 2:25pm revealed:
-She could not remember hearing the RCC yell at

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(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
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a resident on 04/09/19 at 1:50pm.
-She was upset and was not paying attention if there was an incident between a resident and the RCC.

Interview with the RCC on 04/11/19 at 10:20am revealed:
-She had never been disrespectful or rude to the resident at the facility.
-She did tell a resident in the dining room on 04/09/19 that the resident was going to have to wait for her medication.
-She did not remember yelling at the resident.

Confidential interview with a second resident revealed:
-The RCC was mean and yelled at the residents.
-She could not specify how often or the last time she heard the RCC yell at the residents.
-The RCC sometimes got on the "nerves" of the resident because the resident did not like being yelled at.
-The resident tried to "brush it off and did not complain" because the resident believed the RCC was under a lot pressure and did not mean to yell at the residents.

Confidential staff interview revealed:
-The RCC was sometimes disrespectful to the residents.
-The RCC mainly yelled at the residents.
-The RCC "did not know how to talk to the residents when" the RCC "got stressed out".
-The RCC yelled at the residents to "get out of her (the RCC) face" several times but she could not specify the dates and times.
-The staff had not reported any of the incidents to the Administrator because the residents had complained to the Administrator.

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Interview with the Administrator on 04/10/19 at 2:00pm revealed:
-She did not know about any conflicts between any residents and the RCC.
-There had been no complaints and she had not witnessed the RCC speaking harshly or yelling at the residents.

A second interview with the Administrator on 04/11/19 at 8:50am revealed:
-She had spoken with the RCC and believed that the resident was mistaken about the RCC yelling at the resident on 04/09/19.
-The RCC "was joking around and yelled" at another staff and the resident misunderstood and believed the RCC yelled at the resident.

2. Confidential interview with a resident revealed:
-The supervisor had spoken to them loudly and told them "to get out" of her face.
-The supervisor "just did not seem to understand" the resident"s actions and that is when the supervisor yelled at the resident.
-The supervisor made the resident upset when the supervisor yelled at the resident and the resident did not like being yelled at.
-The resident had not complained to the Administrator or any of the other supervisors because the resident hoped that it would get better with the supervisor.

Confidential interview with a second resident on 04/10/19 at 12:00pm revealed:
-The supervisor had been rude to them about three or four weeks ago when the supervisor yelled at the residents and the resident had to put a stop to it.
-The resident fussed back at the supervisor and the staff did not fuss at the resident anymore.
-Staff C continued to fuss at the other residents

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since that incident.

Confidential interview with a third resident on 04/11/19 at 4:30pm revealed:
-Staff C had been talking to the residents roughly about 2-3 weeks ago.
-Staff C had been talking "really" rough in the morning when the residents got up for breakfast and then Staff C calmed down around lunch time.
-Staff C was not as bad as she used to be.
-The resident believed the Administrator knew and had talked to the Staff C about how she spoke to residents.

Interview with Staff C on 04/10/19 at 11:30am revealed:
-She had not been disrespectful to any of the residents at the facility.
-Residents may have misinterpreted her tone but she had not spoken harshly to any of the residents at the facility.
-She had some health issues in January 2019 and she may spoken sharply to the residents when she was in pain; but she was not being disrespectful or rude to the residents.

Interview with the Resident Care Coordinator on 04/11/19 at 10:20am revealed:
-She had never witnessed Staff C being rude or disrespectful.
-No residents had voiced any complaints to her.

Interview with the Administrator on 04/10/19 at 2:00pm revealed:
-She knew there had been some previous problems with Staff C and her tone with the residents about 3 or 4 months ago when Staff C was having a lot of health problems.
-She overheard Staff C speaking harshly to the residents at least two times and she made Staff C

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D911	Continued From page 58 apologize to the residents. -She could not specify the exact time or dates that this occurred. -She finally told Staff C that "she had to get it together" because Staff C was having health problems, worked another facility, and was still talking harshly to the residents. -She told Staff C something had to changes and she "cut back on" the number of hours Staff C worked the facility until she saw Staff C seemed to be doing better health wise. -Staff C was just "under a lot of stress". -She did not know about any other problems with Staff C being verbally abusive to the residents. -No residents had complained to her. ______________________________ The failure of the facility to assure residents were free of verbal abuse resulted in residents being subjected to verbal abuse by staff. These failures by the facility represent abuse and constitutes a Type B Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/10/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 26, 2019.	D911		
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.	D912		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to cardio-pulmonary resuscitiaon training, physical hazards, test for tuberculosis, and criminal background checks.

The findings are:

1. Based on record reviews and interviews, the facility failed to assure at least one staff person was left on the premises at all times who had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 1 of 4 sampled staff (Staff A) for 5 of 23 shifts [Refer to Tag 167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)].

2. Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidenced by storage of oxygen tanks in an unsafe manner in resident room #7, a missing light switch cover and electrical outlet cover in resident room #6, and two missing electrical outlet covers in the residents' dayroom [Refer to Tag 79 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].

3. Based on interviews and record reviews, the

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D912	Continued From page 60 facility failed to assure 3 of 4 sampled staff (Staff A, C, and D) were tested for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services [Refer to Tag 131 10A NCAC 13F .0406(a) Test for Tuberculosis (Type B Violation)]. 4. Based on interviews and record reviews, the facility failed to complete a criminal background check on 1 of 4 sampled staff (Staff D) [Refer to Tag 139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (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	D935		

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NCAC 13F .0503 and 10A NCAC 13G .0503.
(3) Within 60 days from the date of hire, the individual must have completed the following:
a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:
1. The key principles of medication administration.
2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure 2 of 3 sampled medication aides (Staff A and Staff C) had completed the 5, 10, or 15 hour state approved medication training and had been competency evaluated for medication clinical skills prior to administering medication.

The findings are:

Review of the facility's current license revealed the facility underwent a change of ownership effective 09/20/18.

Review of Staff A's, supervisor, personnel record revealed:

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D935	Continued From page 62 -Staff's A date of hire was documented as 01/28/19. -There was documentation Staf A passed the state written medication administration exam on 01/31/12. -There was documentation of a Medication Administration Clinical Skills Competency Validation Checklist dated 03/07/19. -There was no documentation of verification of previous employment as MA within the last 24 months prior to employment at the facility for Staff A. -There was no documentation of completion of the 15-Hour State-approved Medication Administration Training Course for Adult Care Homes for Staff A. Review of the facility's March 2019 medication administration records (MAR) revealed Staff A documented administering medications on 03/09/19, 03/11/19, 03/15/19, 03/18/19, 03/20/19, 03/27/19, and 03/29/19. Interview with Staff A on 04/11/19 at revealed: -She had worked as a supervisor and a medication aide (MA) at the facility for about 3 months and she had worked as MA at a previous facility. -She had not completed the state approved 15 hour medication administration course training since she was hired. -She was competency validated last month by the facility nurse last last month. -She did not know she needed to complete the state approved 15 hour medication administration course training until last month when the Administrator told her about it and the Administrator allowed her to continue to administer medication at the facility. -She had administered medications to the	D935		

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D935	Continued From page 63 residents since she started working at the facility in January 2019. Interview with the Administrator on 04/11/19 at 10:30am revealed: -She believed Staff A had worked previously as a MA at another facility. -She thought that since Staff A had already passed the medication aide test that Staff A only needed to complete the medication clinical skills checklist. -She did not know Staff A needed to complete the 15 hour medication administration training courses since Staff A was already a medication aide. -She had not verified if Staff A had previously been employed as a MA within 24 months prior to working at the facility.	D935		