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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 08/03/22 through 08/05/22.	D 000		
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 interviews and record reviews, the facility failed to ensure 2 of 5 sampled medication	D 164		

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aides (MAs; Staff B and Staff C) who administered insulin, completed training on the care of diabetic residents prior to the administration of insulin.

The findings are:

1. Review of Staff B's personnel record revealed:
-Staff B was hired on 04/29/22 as a MA.
-There was no documentation of training on the care of diabetic residents until 05/17/22.

Review of the April 2022 and May 2022 medication administration record (MAR) revealed:
-Staff B documented administering insulin on 04/29/22 at 4:30pm.
-Staff B documented administering insulin on 05/01/22 - 05/02/22 at 8:30am, 11:30am and 4:30pm.

Telephone interview with Staff B on 08/03/22 at 3:00pm revealed:
-She started work in the facility as a MA in April 2022.
-She began administering insulin her first day at work.
-She took the training of care of diabetic residents a "few weeks" after she started working.

Refer to the interview with the facility contracted nurse consultant on 08/04/22 at 12:15pm.

Refer to the interview with the Administrator on 08/05/22 at 11:23am.

2. Review of Staff C's personnel record revealed:
-Staff C was hired on 08/30/21 as a Medication Aide.
-There was documentation of training on the care of a diabetic resident on 06/01/22.

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D 164	Continued From page 2 Review of April 2022 and May 2022 MARs revealed: -Staff C documented administering insulin on 04/04/22, 04/06/22, 04/11/22 - 04/13/22, 04/17/22 - 04/19/22, 04/21/22 - 04/22/22, 04/25/22, and 04/27/22 - 04/28/22 at 8:30am, 11:30am and 4:30pm. -Staff C documented administering insulin on 04/05/22 and 04/29/22 at 8:30am and 11:30am. -Staff C documented administering insulin on 05/04/22, 05/09/22 - 05/12/22, 05/16/22, 05/18/22 - 05/19/22, 05/23/22 and 05/25/22 - 05/26/22 at 8:30am, 11:30am and 4:30pm. -Staff C documented administering insulin on 05/17/22 and 05/30/22 at 8:30am. Interview with Staff C on 08/04/22 at 11:23am revealed: -She began giving medications at the facility when she started in August 2021. -She had been administering insulin to residents since August of 2021 prior to taking the training for care of diabetic residents on 06/01/22. Refer to the interview with the facility contracted nurse consultant on 08/04/22 at 12:15pm. Refer to the interview with the Administrator on 08/05/22 at 11:23am. _____ Interview with the facility contracted nurse consultant on 08/04/22 at 12:15pm revealed: -She did not have access to employee records, so she arranged staff trainings according to direction from the Administrator or Business Office Manager. -All Medication Aides should have the diabetic training before administering insulin. -She was not aware 2 of the Medication Aides	D 164		

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D 164	Continued From page 3 had administered insulin prior to completing the required training on care of diabetic residents. Interview with the Administrator on 08/05/22 at 11:23am revealed: -The facility contracted nurse consultant was responsible to complete the in-service with the Medication Aides on diabetic training. -Medication Aides should not be administering insulin to residents before completing the diabetic training class. -She was not aware two of the MAs had administered insulin prior to completing the required training on care of diabetic residents.	D 164		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Home And 10A NCAC 13F .0704 Resident Contract, Information On Home And Resident Register (b) The administrator or administrator-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the facility and revise the information on the form as needed. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register. This Rule is not met as evidenced by:	D 248		

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Based on record reviews and interviews the facility failed to ensure the Resident Register was signed and dated by the Administrator for 3 of 3 sampled residents (#1, #2, #3).

The findings are:

1. Review of Resident #1's current FL2 dated 06/23/22 revealed diagnoses included Alzheimer's disease, osteoarthritis, depression, anxiety, lung disease, high blood pressure, atrial fibrillation, elevated cholesterol and history of breast cancer.

Review of Resident #1's Resident Register revealed:
-There was no admission date listed.
-It was not signed or dated by the Administrator.

Refer to interview with the facility's contracted nurse consultant on 08/04/22 at 12:14pm.

Refer to interview with the Administrator on 08/05/22 at 11:22pm.

2. Review of Resident #2's current FL2 dated 05/09/22 revealed diagnoses included vascular dementia, hypertension, elevated cholesterol, bi-polar and history of cerebrovascular accident.

Review of Resident #2's Resident Register revealed:
-An admission date of 12/10/21.
-It was not signed or dated by the Administrator.

Refer to interview with the facility's contracted nurse consultant on 08/04/22 at 12:14pm.

Refer to interview with the Administrator on 08/05/22 at 11:22pm.

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D 248	Continued From page 5 3. Review of Resident #3's current FL2 dated 08/04/21 revealed diagnoses included hypertension, hyperlipidemia and insomnia. Review of Resident #3's Resident Register revealed: -An admission date of 06/03/21. -It was not signed or dated by the Administrator. Refer to interview with the facility's contracted nurse consultant on 08/04/22 at 12:14pm. Refer to interview with the Administrator on 08/05/22 at 11:22pm. _____ Interview with the facility's contracted nurse consultant on 08/04/22 at 12:14pm revealed: -She reviewed newly admitted residents' Resident Registers and gathered any missing information from the resident or the family members. -The Administrator was responsible for signing the Resident Registers. Interview with the Administrator on 08/05/22 at 11:22pm revealed: -She was responsible for signing Resident Registers. -She thought she signed all new Resident Registers. -The facility's contracted nurse should have brought it to her attention that her signature was missing. -The Business Office Manager was authorized to sign the Resident Register if the Administrator was not available to sign it.	D 248		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 6 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 administer medications as ordered for 3 of 4 sampled residents (#1, #2 and #4) related to Lantus [a medication used to treat diabetes (Resident #4)], arimidex (a medication used to treat breast cancer), Eliquis (a medication used for the prevention of blood clots), levothyroxine (a medication for the treatment of underactive thyroid), Perservision A Reds (a supplement used to help preserve vision), vitamin B complex (used as a supplement), vitamin D3 [used as a supplement (Resident #1)] and melatonin [a medication used to treat insomnia (Resident #2)]. The findings are: 1. Review of Resident #4's current FL2 dated 07/14/21 revealed diagnoses included insulin dependent diabetes and congestive heart failure. Review of Resident #4's physicians orders dated 11/17/21 revealed an order for Lantus SoloStar 100units/ml, inject 12 units at bedtime. Review of Resident #4's June 2022 electronic Medication Administration Record (eMAR) revealed:	D 358		

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-There was an entry for Lantus SoloStar, inject 12 units at bedtime.
-There was documentation 6 of 12 scheduled units of Lantus SoloStar was administered on 06/24/22 because it was out of stock.
-There was documentation Lantus SoloStar was not administered on 06/25/22 and 06/26/22 but a reason was not documented.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/05/22 at 10:05am revealed:
-All insulin refills needed to be requested when it was running low becasue insulin was not routinely sent with the monthly cycle fill.
-The Lantus refill was requested on 06/24/22 at 7:50pm and delivered to the facility on 06/27/22.

Interview with the Administrator on 08/05/22 at 11:22am revealed she was not aware insulin needed to be reordered every month because it was not delivered monthly with the facility's cycle fill medications.

Refer to interview with the facility's contracted nurse consultant on 08/04/22 at 12:14pm.

Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/05/22 at 10:05am.

Refer to interview with the Administrator on 08/05/22 at 11:22am.

2. Resident #1's current FL-2 dated 06/23/22 revealed:
-Diagnoses included Alzheimer's disease, breast cancer, hypothyroidism and atrial fibrillation (causes an irregular heart rhythm).
-A medication order for arimidex (used to treat

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breast cancer) 1mg tablet daily.
-A medication order for Eliquis (used to treat atrial fibrillation) 5mg tablet twice daily.
-A medication order for levothyroxine (used to treat hypothyroidism) 75mcg tablet daily.
-A medication order for Perservision A Reds (used to help preserve vision) 1 capsule twice daily.
-A medication order for vitamin B complex (vitamin supplement) 1 capsule daily.
-A medication order for vitamin D3 (vitamin supplement) 1000 international units (IU) tablet daily.

a. Review of Resident #1's electronic Medication Administration Record (eMAR) for August 2022 revealed:
-There was an entry for arimidex 1mg tablet daily with a scheduled administration time of 8:00am.
-Arimidex was not documented as administered on 08/03/22 due to "physically unable to take."

Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no arimidex available for administration.

b. Review of Resident #1's eMAR for August 2022 revealed:
-There was an entry for Eliquis 5mg tablet twice daily with a scheduled administration time of 8:00am and 6:00pm.
-Eliquis was not documented as administered on 08/03/22 due to "physically unable to take."

Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no Eliquis available for administration.

Interview with the facility's contracted nurse practitioner on 08/04/22 at 12:14pm revealed:

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-Resident #1 missing a dose of Eliquis was concerning to her.
-Resident #1 was prescribed Eliquis to help prevent blood clots..
-Missing one dose was not critical, but it was not ideal since Resident #1 takes Eliquis twice a day.

c. Review of Resident #1's eMAR for August 2022 revealed:
-There was an entry for levothyroxine 75mcg tablet daily with a scheduled administration time of 6:00am.
-Levothyroxine was not documented as administered on 08/03/22 due to "out of facility."

Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no levothyroxine available for administration.

d. Review of Resident #1's eMAR for August 2022 revealed:
-There was an entry for Perservision A Reds one capsule twice daily with a scheduled administration time of 8:00am and 6:00pm.
-Perservision A Reds was not documented as administered on 08/03/22 due to "physically unable to take."

Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no Perservision A Reds available for administration.

e. Review of Resident #1's eMAR for August 2022 revealed:
-There was an entry for vitamin B complex one capsule daily with a scheduled administration time of 8:00am.
-Vitamin B complex was not documented as administered on 08/03/22 due to "physically

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unable to take."

Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no vitamin B complex available for administration.

f. Review of Resident #1's eMAR for August 2022 revealed:
-There was an entry for vitamin D3 1000 IU tablet daily with a scheduled administration time of 8:00am.
-Vitamin D3 was not documented as administered on 08/03/22 due to "physically unable to take.".

Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no vitamin D3 available for administration.

Refer to telephone interview with a 2nd Medication Aide (MA) on 08/03/22 at 2:51pm.

Refer to telephone interview with a 3rd MA on 08/03/22 at 3:00pm.

Refer to interview with the facility's contracted nurse consultant on 08/04/22 at 12:14pm.

Refer to Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/05/22 at 10:05am.

Refer to interview with the Administrator on 08/05/22 at 11:22am.

3. Review of Resident #2's current FL2 dated 05/09/22 revealed:
-Diagnoses included vascular dementia, hypertension, elevated cholesterol, bi-polar and history of cerebrovascular accident.

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D 358	Continued From page 11 -There was an order for melatonin 1mg at bedtime. Review of Resident #2's August 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for melatonin 1mg at bedtime. -Melatonin 1mg was documented as not administered on 08/02/22 due to out of facility. Observation of Resident #2's medications on hand on 08/03/22 at 3:00pm revealed there was no melatonin 1mg available for administration. Interview with a Medication Aide (MA) on 08/03/22 at 3:00pm revealed: -Resident #2's melatonin was scheduled to be delivered by pharmacy later in the day along with all the facility's cycle fill medications. -She did not know why the melatonin ran out before the new cycle fill was delivered. -Resident #2 was not out of the facility on 08/02/22. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/05/22 at 10:05am revealed: -The facility's routine oral medications were delivered by the pharmacy at the beginning of each month. -The facility needed to request a refill for any routine medication that ran out before they were scheduled to be refilled. -Resident #2's melatonin was last delivered on 08/03/22. Refer to interview with the facility's contracted nurse consultant on 08/04/22 at 12:14pm.	D 358		

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D 358	Continued From page 12 Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/05/22 at 10:05am. Refer to interview with the Administrator on 08/05/22 at 11:22am. _____ Telephone interview with a second Medication Aide (MA) on 08/03/22 at 2:51pm revealed: -She was instructed by a Resident Care Coordinator (RCC) who no longer worked at the facility to document "physically unable to take" if the medication was not in the facility. -She was told by the same RCC that documenting "physically unable to take" on the eMAR was the best choice for documentation if the medication was not available in the facility. -There was not an option to choose on the eMAR that indicated the medication was not available in the facility. Telephone interview with a third MA on 08/03/22 at 3:00pm revealed: -Another MA had told her to document "out of facility" on the eMAR if the medication was not available in the facility. -This did not mean the resident was out of the facility. -It meant the medication had not arrived from the pharmacy yet, so the medication was "out of facility." Interview with the facility's contract nurse consultant on 08/04/22 at 12:14pm revealed: -Medication cart audits were conducted monthly by the 3rd shift MA when the new cycle fill medications were delivered from the pharmacy. -Her expectation was for medications to be ordered timely and available in the facility at administration times.	D 358		

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D 358	Continued From page 13 Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/05/22 at 10:05am revealed: -He was responsible for the monthly medication cycle fill for the facility. -He had multiple conversations with MAs at the facility about ordering medications timely because medications were sent through the mail and it took about 2 days before they would be delivered. -He instructed MAs to submit refill requests when there were about 5 doses left. Interview with the Administrator on 08/05/22 at 11:22am revealed: -MAs were trained to reorder medications when they had about 5 doses left and would be out before the monthly cycle fill was delivered from the pharmacy. -The MA working on the medication cart was responsible for reordering medications from the pharmacy.	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;	D 367		

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D 367	Continued From page 14 (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: Based on observations, record review and interviews, the facility failed to ensure the accuracy of the electronic Medication Administration Record (eMAR) for 2 of 3 sampled residents (Resident #1 and #2) related to arimidex (used to treat breast cancer), Eliquis (used to prevent the formation of blood clots), levothyroxine (used for treatment of underactive thyroid), Perservision A Reds (a supplement used to help preserve vision), vitamin B complex (used for vitamin supplementation), vitamin D3 [used for vitamin supplementation (Resident #1)] and melatonin [used as a sleep aide (Resident #2)]. The findings are: 1. Review of Resident #1's current FL2 dated 06/23/22 revealed: -Diagnoses included Alzheimer's disease, breast cancer, hypothyroidism and atrial fibrillation (causes an irregular heart rhythm). -A medication order for arimidex (used to treat breast cancer) 1mg tablet daily. -A medication order for Eliquis (used to treat atrial fibrillation) 5mg tablet twice daily. -A medication order for levothyroxine (used to treat hypothyroidism) 75mcg tablet daily. -A medication order for Perservision A Reds (used to help preserve vision) 1 capsule twice	D 367		

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D 367	Continued From page 15	D 367		

daily.
-A medication order for vitamin B complex (vitamin supplement) 1 capsule daily.
-A medication order for vitamin D3 (vitamin supplement) 1000 international units (IU) tablet daily.

a. Review of Resident #1's electronic Medication Administration Record (eMAR) for August 2022 revealed:
-There was an entry for arimidex 1mg tablet daily with an administration time of 8:00am.
-There was documentation on the eMAR at 7:32am on 08/03/22 Resident #1 was "physically unable to take" the arimidex.

Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no arimidex available for administration.

b. Review of Resident #1's eMAR for August 2022 revealed:
-There was an entry for Eliquis 5mg tablet twice daily with an administration time of 8:00am and 6:00pm.
-There was documentation on the eMAR at 7:32am on 08/03/22 Resident #1 was "physically unable to take" the Eliquis.

Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no Eliquis available for administration.

c. Review of Resident #1's eMAR for August 2022 revealed:
-There was an entry for levothyroxine 75mcg tablet daily with an administration time of 6:00am.
-There was documentation on the eMAR at 5:04am on 08/03/22 Resident #1 was "out of facility".

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D 367	Continued From page 16 Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no levothyroxine available for administration. d. Review of Resident #1's eMAR for August 2022 revealed: -There was an entry for Perservision A Reds 1 capsule twice daily with an administration time of 8:00am and 6:00pm. -There was documentation on the eMAR at 7:32am on 08/03/22 Resident #1 was "physically unable to take" the Perservision A Reds. Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no Perservision A Reds available for administration. e. Review of Resident #1's eMAR for August 2022 revealed: -There was an entry for vitamin B complex one capsule daily with an administration time of 8:00am. -There was documentation on the eMAR at 7:32am on 08/03/22 Resident #1 was "physically unable to take" the vitamin B complex. Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no vitamin B complex available for administration. f. Review of Resident #1's eMAR for August 2022 revealed: -There was an entry for vitamin D3 1000 IU tablet daily with an administration time of 8:00am. -There was documentation on the eMAR at 7:32am on 08/03/22 Resident #1 was "physically unable to take" the vitamin D3.	D 367		

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D 367	Continued From page 17 Observation of Resident #1's medications on hand on 08/03/22 at 2:15pm revealed there was no vitamin D3 available for administration. Refer to telephone interview with a second Medication Aide (MA) on 08/03/22 at 2:51pm. Refer to telephone interview with a third MA on 08/03/22 at 3:00pm. Refer to interview with the Administrator on 08/05/22 at 11:23am. 2. Review of Resident #2's current FL2 dated 05/09/22 revealed: -Diagnoses included vascular dementia, hypertension, elevated cholesterol, bi-polar and history of cerebrovascular accident. -There was an order for melatonin 1mg at bedtime. Review of Resident #2's August 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for melatonin 1mg at bedtime. -Melatonin 1mg was documented as not administered on 08/02/22 due to out of facility. Observation of Resident #2's medications on hand on 08/03/22 at 3:00pm revealed there was no melatonin 1mg available for administration. Interview with a Medication Aide (MA) on 08/03/22 at 3:00pm revealed: -Resident #2's melatonin was scheduled to be delivered by pharmacy later in the day along with all the facility's cycle fill medications. -The MA who documented Resident #2 was out of facility on 08/02/22 should have documented	D 367		

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D 367	Continued From page 18 melatonin was out of stock. Refer to telephone interview with a second Medication Aide (MA) on 08/03/22 at 2:51pm revealed: Refer to telephone interview with a third MA on 08/03/22 at 3:00pm. Refer to interview with the Administrator on 08/05/22 at 11:23am. _____ Telephone interview with a second Medication Aide (MA) on 08/03/22 at 2:51pm revealed: -She was instructed by a Resident Care Coordinator (RCC) who no longer worked at the facility to document "physically unable to take" if the medication was not in the facility. -She was told by the same RCC that documenting "physically unable to take" on the eMAR was the best choice for documentation if the medication was not available in the facility. -There was not an option to choose on the eMAR that indicated the medication was not available in the facility. Telephone interview with a third MA on 08/03/22 at 3:00pm revealed: -Another MA had told her to document "out of facility" on the eMAR if the medication was not available in the facility. -This did not mean the resident was out of the facility. -It meant the medication had not arrived from the pharmacy yet, so the medication was "out of facility." Interview with the Administrator on 08/05/22 at 11:23am revealed: -The MAs were trained how to re-order	D 367		

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D 367	Continued From page 19 medications. -If a medication was not available to administer, the MA was supposed to document their initials on the eMAR, then circle their initials, which indicated the medication was not given. -The MA was supposed to document the accurate reason the medication was not available and since there was not a dropdown option to choose from she should have documented a reason in the the notes section.	D 367		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to notify the County Department of Social Services (DSS) of an incident/accident that required emergency medical evaluation for 1 of 3 residents (Resident #1) with injuries after a fall. The findings are: Review of Resident #1's current FL-2 dated 06/23/22 revealed: -Diagnoses included Alzheimer's disease, osteoarthritis and degenerative disc disease. -The resident was semi-ambulatory with the use	D 451		

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D 451	Continued From page 20	D 451		

of a walker.

Observation of Resident #1 on 08/03/22 at 9:45am revealed she was wearing a soft brace on her right wrist and lower right arm.

Interview with Resident #1 on 08/03/22 at 9:45am revealed she was unable to remember what happened to her right wrist and lower right arm.

Review of Resident #1's incident/accident report dated 06/17/22 and timed for 1:00pm revealed:
-Resident #1 lost her balance and fell.
-Resident #1 verbalized to the medication aide (MA) her right wrist was hurting.
-The MA notified the primary care provider (PCP) and a family member for Resident #1.
-Resident #1 was taken to the hospital by the Business Office Manager (BOM).

Telephone interview with a representative from the local DSS on 08/03/22 at 11:50am revealed:
-There was not an incident/accident report received from the facility related to Resident #1 on or after 06/17/22.
-She expected the facility to notify DSS when an incident occurred resulting in an emergency room (ER) visit or hospitalization for any resident with an injury requiring medical treatment.

Interview with the MA on 08/03/22 at 12:20pm revealed:
-She witnessed Resident #1's fall on 06/17/22 and wrote the incident/accident report.
-She did not contact the local DSS representative about Resident #1's fall.
-She did not know who was responsible to contact the local DSS.

Interview with the BOM on 08/04/22 at 4:22pm

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D 451	Continued From page 21 revealed: -She did not know a report should have been sent to DSS about Resident #1's fall with an injury. -The Administrator was responsible for notifying DSS. Interview with the Administrator on 08/05/22 at 11:23am revealed: -Whenever an incident occurred that resulted in an injury to a resident, the MA was responsible to let the local DSS know. -She was unaware the MA had not contacted the local DSS after Resident #1 broke her wrist. -She did not know the local DSS was only notified if the resident was sent out to the emergency room and received treatment.	D 451		
D 610	10A NCAC 13F .1801 (a) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement an infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection of the residents during the global	D 610		

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D 610	Continued From page 22 coronavirus (COVID-19) pandemic related to the use of personal protective equipment (PPE) by staff. The findings are: Review of the 01/21/22 CDC guidelines for the prevention and spread of the coronavirus in a long-term care (LTC) facility revealed: -Personnel should always wear a face mask in the facility. -Face masks should not be worn under the nose or mouth. -A surgical mask can be used if a N95 mask is not available. -Appropriate PPE should be used by personnel when coming in contact with the resident. Review of the 11/19/21 NCDHHS guidelines for the prevention and spread of the coronavirus in LTC facilities revealed all facility staff should wear a face mask while in the facility. Attempted review of the facility's Infection Control Policy revealed the facility did not have established Infection Control policies or procedures. Observation upon entry to the facility on 08/03/22 at 9:00am revealed the Business Office Mananger (BOM) was not wearing a face mask. Interview with the BOM on 08/03/22 at 9:00am revealed: -All staff, except one, were fully vaccinated. -The facility did not require a face mask if the preson was fully vaccinated. Observation of the dining room on 08/03/22 at 11:55am revealed:	D 610		

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D 610	Continued From page 23 -The BOM, a Medication Aide (MA) and a Personal Care Aide (PCA) were serving meals in the dining room. -None of them were wearing a face mask. Observation of a MA on 08/03/22 at 3:00pm revealed she was not wearing a face mask. Interview with the BOM on 08/04/22 at 8:22am revealed the Administrator and the facility's contracted nurse consultant made the decision to have staff stop wearing face masks over a month ago based on the current CDC and state guidelines. Observation of a MA on 08/04/22 at 8:30am revealed she was not wearing a face mask. Obsrvation of a MA on 08/04/22 at 11:23am revealed she was not wearing a face mask. Interview with a MA on 08/04/22 at 11:23am revealed: -The facility stopped the requirement for staff wearing masks in April 2022. -Personnel only have to wear a mask if they had not been vaccinated. Observation of the facility's contracted nurse consultant on 08/04/22 at 12:14pm revealed she was not wearing a face mask. Interview with the facility's contracted nurse consultant on 08/04/22 at 12:14pm revealed: -She used the CDC recommendations and state guidelines to make her decision to stop wearing masks. -Staff did not need to wear a mask if they were fully vaccinated. Interview with the Administrator on 08/05/22 at	D 610		

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D 610	Continued From page 24 11:22am revealed: -The facility's contracted nurse consultant reviewed the need for continuing to wear face masks and made the recommendation that fully vaccinated staff no longer needed to wear a face mask. -Fully vaccinated staff stopped wearing face masks a couple months ago. -She received COVID-19 information and recommendations from the state. -The local community stopped requiring face masks. -She did not receive information from the state that face masks could be discontinued but she thought the facility could do the same as the local community.	D 610		
D 611	10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette;	D 611		

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D 611	Continued From page 25 (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen; (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working; (6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease	D 611		

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outbreak;
(7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance
on infection control; and
(8) a process for updating policies and procedures to reflect guidelines and recommendations by the
CDC, local health department, and North Carolina Department of Health and Human Services
(NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure policies and procedures were established and implemented consistent with the federal CDC guidelines related to standard and transmission based precautions related to Coronavirus COVID-19.

The findings are:

Review of the facility's undated Infection Control Training Manual revealed:
-There was no information related to the coronavirus (COVID-19) in the manual.
-The training manual contained general infection control information but did not contain any facility policies or procedures related to infection control or COVID-19.

Interview with the Administrator on 08/05/22 at 10:41am revealed:
-She thought she had updated the infection control policies and procedures at the start of the COVID-19 pandemic in 2020.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 611	Continued From page 27 -She did not know where the policy and procedure manual was. -She thought the facility's contracted nurse consultant had the infection control policy and procedure manual because she was rewriting them, but she could not locate them in her office. Interview with the Business Office Manager on 08/05/22 at 11:11am revealed: -There was an infection control training manual that included general infection control information but there were not any written policies or procedures for infection control or COVID-19. -She did not know that specific policy and procedures, including those related to COVID-19, were needed in addition to the training manual. Interview with the facility's contracted nurse consultant on 08/04/22 at 12:15am revealed: -She taught the infection control (IC) class at the facility using the IC "teacher's manual". -The manual had not been updated with COVID-19 information but she presented material to the staff about COVID-19 when she taught the IC class. -She was not sure where the policies and procedures manual for infection control was. -The Administrator should have the policies and procedures for infection control in her office.	D 611		
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	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	08/05/2022

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D935	Continued From page 28 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 Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled medication aides (Staff C) had completed and passed the written state medication aide examination prior to	D935		

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	HAL056005	A. BUILDING: _____ B. WING _____	08/05/2022

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D935	Continued From page 29 administering medications without supervision. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired on 08/23/21 as a personal care aide (PCA). -Staff C was hired on 08/30/21 as a Medication Aide (MA). -There was documentation Staff C had successfully completed the 15-hour training requirement 08/26/21 - 08/27/21 and the Medication Administration Clinical Skills checklist on 08/27/21. -There was no documentation Staff C had completed and passed the written state examination. Interview with the Business Office Manager (BOM) on 08/03/22 at 10:22am revealed: -Staff C had been administering medications since August 2021. -Staff C administered medications to all residents including insulin and blood thinners. -She was aware Staff C had tried numerous times unsuccesfully to schedule her state examination. Interview with Staff C on 08/04/22 at 11:23am revealed: -She had been administering medications to the residents since she started in August 2021. -She was scheduled to take her medication exam on 08/12/22. -She had completed her 15-hour training and her Medication Administration Clinical Skills Checklist with a representative from the facility's contracted pharmacy. -The pharmacy representative told her she had to complete the medication exam within 60 days of	D935		

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D935	Continued From page 30	D935		

completing her Medication Administration Clinical Skills checklist .
-She had difficulties arranging to take the medication exam due to a change in her last name.
-She tried multiple times to register but was unable to do so until 08/03/22 when she was able to register to take the medication exam on 08/12/22.
-She was not supervised by anyone when she administered medications.
-She was not aware she could not give medications without supervision until she had completed and passed her medication aide examination.

Interview with the contracted facility nurse consultant on 08/04/22 at 12:15pm revealed:
-She did not have access to personnel records for staff.
-She completed trainings and classes based on what she was told by the BOM or Administrator was needed.
-She was not aware Staff C or Staff E had not taken the medication exam as of 08/04/22.
-Staff C and Staff E should not be administering medications without supervision until they completed and passed the medication exam.

Interview with the Administrator on 08/05/22 at 11:23am revealed:
-The facility's contracted nurse consultant was responsible to ensure the MAs had completed all steps necessary to pass medications without supervision.
-She was not aware Staff C and Staff E had not taken and passed their medication examination.
-The BOM was responsible for verifying staff credentials.