

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL001029</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/01/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SPRINGVIEW - STEWART BUILDING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>611 W WHITSETT STREET<br/>GRAHAM, NC 27253</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| D 000                                                                    | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on June 1, 2017.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | D 000                                                                                      |                                                                                                                          |                                                        |
| D935                                                                     | G.S. § 131D-4.5B(b) ACH Medication Aides;<br>Training and Competency<br><br>G.S. § 131D-4.5B (b) Adult Care Home<br>Medication Aides; Training and Competency<br>Evaluation Requirements.<br><br>(b) Beginning October 1, 2013, an adult care<br>home is prohibited from allowing staff to perform<br>any unsupervised medication aide duties unless<br>that individual has previously worked as a<br>medication aide during the previous 24 months in<br>an adult care home or successfully completed all<br>of the following:<br>(1) A five-hour training program developed by the<br>Department that includes training and instruction<br>in all of the following:<br>a. The key principles of medication<br>administration.<br>b. The federal Centers for Disease Control and<br>Prevention guidelines on infection control and, if<br>applicable, safe injection practices and<br>procedures for monitoring or testing in which<br>bleeding occurs or the potential for bleeding<br>exists.<br>(2) A clinical skills evaluation consistent with 10A<br>NCAC 13F .0503 and 10A NCAC 13G .0503.<br>(3) Within 60 days from the date of hire, the<br>individual must have completed the following:<br>a. An additional 10-hour training program<br>developed by the Department that includes<br>training and instruction in all of the following:<br>1. The key principles of medication<br>administration.<br>2. The federal Centers of Disease Control and<br>Prevention guidelines on infection control and, if | D935                                                                                       |                                                                                                                          |                                                        |

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

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| D935                                                                     | <p>Continued From page 1</p> <p>applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.</p> <p>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation, interview and record review revealed the facility failed to assure a medication aide (C) hired on or after October 1, 2013 completed the 5 hour and the 10 hour medication aide course of training and instruction developed by the Department to assist qualified instructors to train unlicensed staff who administer medications to residents.</p> <p>The findings are:</p> <p>Review of the employee record for Staff C, medication aide (MA) revealed:</p> <ul style="list-style-type: none"> <li>- The MA was hired on 8/20/14.</li> <li>- She was hired as a "Caregiver."</li> <li>- There was documentation of a clinical skills competency validation dated 8/28/14.</li> <li>- A written medication administration examination was passed on 10/10/14.</li> <li>- There was no documentation of completion of the 5 hour and 10 hour medication administration training and instruction program.</li> </ul> <p>Interview on 5/31/17 at 11:45 a.m. with the MA revealed:</p> <ul style="list-style-type: none"> <li>- She had worked as a fill-in MA in the facility 1-2 days a week.</li> <li>- She passed medication, administered insulin and obtained fingerstick blood sugar checks with</li> </ul> | D935                                                                                       |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D935                                                                     | <p>Continued From page 2</p> <p>residents.</p> <ul style="list-style-type: none"> <li>- She had all of her medication administration training and had passed the written medication test.</li> </ul> <p>Interview on 6/01/17 at 4:54 p.m. with the facility supervisor revealed:</p> <ul style="list-style-type: none"> <li>- The MA had completed all of her medication training and had been working as a medication aide since 2014.</li> <li>- All of the training for staff was completed from a video training company.</li> <li>- He would look for Staff C's Medication aide training in the office.</li> </ul> <p>After the survey, the facility provided the following:</p> <ul style="list-style-type: none"> <li>- A 5 hour Medication Administration Training Course dated 8/20/14 signed by the facility supervisor as the "Trainer".</li> <li>- There were no "Including licensing credentials" of a qualified instructor listed next to the "Trainers" signature on the Certification of Completion as required.</li> <li>- A 10 hour Medication Administration Training Course dated 10/11/14 signed by the facility supervisor as the "Trainer".</li> <li>- There were no "Including licensing credentials" of a qualified instructor listed next to the "Trainers" signature on the Certification of Completion as required.</li> </ul> | D935                                                                                       |                                                                                                                          |                                                        |