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D 000	Initial Comments The Adult Care Licensure Section completed an annual survey on August 16, 2022 and August 17, 2022.	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 6 of 6 sampled medication	D 164		

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aides (Staff A, B, C, D, E and F) who administered insulin and performed finger stick blood sugars, completed training on the care of diabetic residents prior to the administration of insulin.

The findings are:

Review of course information of the facility's computer-based online training module titled The Basics of Diabetes revealed:
-The computer-based training was revised by a Registered Nurse (RN).
-The computer-based training included basic facts/care of diabetes, insulin actions, treatment of hypoglycemia and hyperglycemia with signs and symptoms, universal precautions, tips for performing finger stick blood sugars and appropriate times to administer insulin.
-The computer-based training did not include insulin storage, mixing/measuring and injection techniques for insulin administration, blood glucose monitoring and sliding scale insulin administration.
-The computer-based training did not allow for hands on return demonstration of performing finger stick blood sugars or measuring and administering insulin by injection.

1. Review of Staff A's personnel record revealed:
-Staff A was hired on 11/01/19 as a medication aide (MA)/personal care aide (PCA).
-There was documentation a computer-based training module on diabetes basics was completed on 10/22/20.

Review of the June 2022-August 2022 electronic medication administration records (eMARs) revealed Staff A documented finger stick blood sugar (FSBS) and insulin administration 2 times

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in June 2022, 3 times in July 2022, and 2 times between 08/01/22 and 08/15/22.

Telephone interview with Staff A on 08/17/22 at 3:15pm revealed:
-She began working at the facility in 2019 as a MA/PCA.
-She had worked at the facility under different ownership since 2016.
-She thinks she had a computer based diabetic care training, but she had not had hands on, return demonstration of fingerstick blood sugars (FSBS) and insulin administration with a registered nurse (RN), pharmacist, or prescribing practitioner.

Refer to interview with the Business Office Manager (BOM) on 08/17/22 at 3:29pm.

Refer to the interview with the RCD on 08/17/22 at 4:12pm.

Refer to the interview with the Administrator on 08/17/22 at 4:51pm.

2. Review of Staff B's personnel record revealed:
-Staff B was hired on 08/21/20 as a personal care aide (PCA) and became a medication aide (MA) on 11/21/21.
-There was no documentation Staff B had any diabetic care training.

Review of the June 2022-July 2022 electronic medication administration records (eMARs) revealed:
-Staff B documented finger stick blood sugar (FSBS) and insulin administration 3 times in June 2022.
-Staff B documented FSBS 6 times and insulin administration 5 times in July 2022.

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D 164	Continued From page 3 Attempted telephone interview with Staff B on 08/17/22 at 4:27pm was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 08/17/22 at 3:29pm. Refer to the interview with the RCD on 08/17/22 at 4:12pm. Refer to the interview with the Administrator on 08/17/22 at 4:51pm. 3. Review of Staff C's personnel record revealed: -Staff C was hired on 07/12/21 as a personal care aide (PCA) and became a medication aide (MA) on 09/26/21. -There was documentation a computer-based training module on diabetes basics was completed on 12/13/21. Review of the June 2022-August 2022 electronic medication administration records (eMARs) revealed Staff C documented finger stick blood sugar (FSBS) and insulin administration 20 times in June 2022, 31 times in July 2022, and 4 times between 08/01/22 and 08/15/22. Telephone interview with Staff C on 08/17/22 at 3:15pm revealed: -She began working at the facility as a PCA in July 2021 and started working as a MA in September 2021. -She did not remember completing any diabetic care trainings where she had hands on, return demonstration of fingerstick blood sugars (FSBS) and insulin administration with a registered nurse (RN), pharmacist, or prescribing practitioner. -The Resident Care Director (RCD) or the Business Office Manager (BOM) told her what	D 164		

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trainings she needed to complete.

Refer to interview with the Business Office Manager (BOM) on 08/17/22 at 3:29pm.

Refer to the interview with the RCD on 08/17/22 at 4:12pm.

Refer to the interview with the Administrator on 08/17/22 at 4:51pm.

4. Review of Staff D's personnel record revealed:
-Staff D was hired on 08/05/20 as a MA.
-There was documentation of computer-based online training module on the care of diabetic residents dated 04/14/21.

Review of the June 2022-August 2022 electronic medication administration records (eMARs) revealed:
-Staff D documented finger stick blood sugar (FSBS) on 4 opportunities.
-Staff D documented administering insulin on 4 opportunities.

Interview with Staff D on 08/17/22 at 3:15pm revealed:
-He started work in the facility as a MA in August 2020.
-He began administering insulin as an MA.
-He took the computer-based online training module for the care of diabetic residents and reviewed insulin in his 15-hour medication administration training.
-He did not have hands on return demonstration of FSBS and insulin administration with an RN, pharmacist or prescribing practitioner.

Refer to interview with the Business Office Manager (BOM) on 08/17/22 at 3:29pm.

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D 164	Continued From page 5 Refer to the interview with the RCD on 08/17/22 at 4:12pm. Refer to the interview with the Administrator on 08/17/22 at 4:51pm. 5. Review of Staff E's personnel record revealed: -Staff E was hired on 05/13/22 as a Medication Aide. -There was documentation of computer-based online training module on the care of diabetic residents dated 05/12/22. Review of the July 2022 and August 2022 eMAR revealed: -Staff E documented FSBS on 1 opportunity. -Staff E documented administering insulin on 31 opportunities. Interview with Staff E on 08/17/22 at 3:10pm revealed: -She started work in the facility as a MA in May 2022. -She began performing FSBS and administering insulin her first day as an MA. -She took the computer-based online training module for the care of diabetic residents and took a test on insulin in her 15-hour medication administration training. -She did not remember having hands on return demonstration of FSBS and insulin administration with an RN, pharmacist or prescribing practitioner. Refer to interview with the Business Office Manager (BOM) on 08/17/22 at 3:29pm. Refer to the interview with the RCD on 08/17/22 at 4:12pm.	D 164		

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D 164	Continued From page 6 Refer to the interview with the Administrator on 08/17/22 at 4:51pm. 6. Review of Staff F's personnel record revealed: -Staff F was hired on 05/13/22 as a Medication Aide. -There was documentation of computer-based online training module on the care of diabetic residents dated 05/12/22. Review of the June 2022-August 2022 eMAR revealed: -Staff F documented FSBS on 1 opportunity. -Staff F documented administering insulin on 5 opportunities. Interview with Staff F on 08/17/22 at 3:20pm revealed: -She started work in the facility as a MA in May 2022. -She began performing FSBS and administering insulin when she became an MA. -She took the computer-based online training module for the care of diabetic residents and insulin in her 15-hour medication administration training. -She did not have hands on return demonstration of FSBS and insulin administration with an RN, pharmacist or prescribing practitioner. Refer to interview with the Business Office Manager (BOM) on 08/17/22 at 3:29pm. Refer to the interview with the RCD on 08/17/22 at 4:12pm. Refer to the interview with the Administrator on 08/17/22 at 4:51pm.	D 164		

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D 164	Continued From page 7 Interview with the Business Office Manager (BOM) on 08/17/22 at 3:29pm revealed: -She was responsible for setting up the computer based diabetic care trainings for staff. -She did not know diabetic care trainings were to be instructed by a RN, pharmacist, or prescribing practitioner. -She did not know detailed areas of diabetic care covered by the computer based diabetic care training. Interview with the RCD on 08/17/22 at 4:12pm revealed: -She and the BOM were responsible to work together to ensure all trainings were completed for staff including diabetic care training. -She knew diabetic care training was required for staff prior to administration of insulin. -She thought the training on the care of the diabetic resident was include in the 15-hour medication training and did not know the training on the care of the diabetic resident should have been a separate training. Interview with the Administrator on 08/17/22 at 4:51pm revealed: -The RCD and the BOM were responsible for ensuring all staff trainings were completed. -She thought diabetic care training was included with the 15-hour medication training and medication aides were checked off for diabetic care by a nurse. -She did not know there should have been a separate training for care of the diabetic resident provided by a registered nurse (RN), a pharmacist, or a prescribing practitioner and should have included basic facts about diabetes and care involved in the management of diabetes; insulin action; insulin storage, mixing, measuring and injection	D 164		

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D 164	Continued From page 8 techniques for insulin administration; treatment and prevention of hypoglycemia and hyperglycemia; including signs and symptoms; blood glucose monitoring; universal precautions; universal precautions; appropriate administration times; and sliding scale insulin administration. -Medication aides (MA) completed computer based diabetic trainings and she thought all required areas for care of the diabetic resident were covered between the 15-hour medication training and the computer based diabetic trainings.	D 164		
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 observation, interviews, and record review, the facility failed to ensure medications and treatments were administered as prescribed to 2 of 6 residents (#1 and #4), regarding sliding scale insulin (#1) and an antispasmodic (#4). The findings are: 1. Review of Resident #1's current FL2 dated 11/17/21 revealed: -Diagnoses included type II diabetes, hyperlipidemia, and chronic renal disease.	D 358		

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-There was an order for Humalog injection 100 units (u) check and record fingerstick blood sugar (FSBS) before meals and at bedtime, inject per sliding scale insulin (SSI): 200-250= 2u, 251-300= 4u, 301-350= 6u, 351-400= 8u, over 400= call physician.

Review of Resident #1's physician's orders dated 05/17/22 revealed an order to check FSBS and record with meals and at bedtime and inject per SSI: 160-200= 1u, 201-240= 2u, 241-280= 3u, 281-320= 4u, 321-360= 5u, 361-400= 6u, 401 or greater 7u.

Review of Resident #1's electronic medication administration record (eMAR) for June 2022 revealed:
-There was an entry for Humalog 100/mL check and record FSBS with meals and at bedtime and inject per SSI: 160-200= 1u, 201-240= 2u, 241-280= 3u, 281-320= 4u, 321-360= 5u, 361-400= 6u, 401 or greater 7u scheduled for administration at 8:00am, 12:00pm, 5:00pm, and 8:00pm.
-There was documentation Humalog was not administered according to the sliding scale for 12 of 120 opportunities between 06/01/22 and 06/30/22.
-On 06/03/22 at 5:00pm, FSBS was 280 and 1u of Humalog was documented as administered, but 3u should have been administered.
-On 06/06/22 at 8:00am, FSBS was 228 and 1u of Humalog was documented as administered, but 2u should have been administered.
-On 06/10/22 at 5:00pm, FSBS was 283 and 2u of Humalog was documented as administered, but 4u should have been administered.
-On 06/12/22 at 12:00pm, FSBS was 168 and 0u of Humalog was documented as administered, but 1u should have been administered.

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-On 06/13/22 at 12:00pm, FSBS was 110 and 1u of Humalog was documented as administered, but 0u should have been administered.
-On 06/13/22 at 5:00pm, FSBS was 369 and 5u of Humalog was documented as administered, but 6u should have been administered.
-On 06/14/22 at 12:00pm, FSBS was 130 and 2u of Humalog was documented as administered, but 0u should have been administered.
-On 06/17/22 at 8:00am, FSBS was 100 and 1u of Humalog was documented as administered, but 0u should have been administered.
-On 06/17/22 at 12:00pm, FSBS was 225 and 3u of Humalog was documented as administered, but 2u should have been administered.
-On 06/17/22 at 8:00pm, FSBS was 289 and 3u of Humalog was documented as administered, but 4u should have been administered.
-On 06/25/22 at 5:00pm, FSBS was 183 and 0u of Humalog was documented as administered, but 1u should have been administered.
-On 06/28/22 at 5:00pm, FSBS was 419 and 5u of Humalog was documented as administered, but 7u should have been administered.
-Resident #1's FSBS ranged from 61 to 419.

Review of Resident #1's eMAR for July 2022 revealed:
-There was an entry for Humalog 100/mL check and record FSBS with meals and at bedtime and inject per SSI: 160-200= 1u, 201-240= 2u, 241-280= 3u, 281-320= 4u, 321-360= 5u, 361-400= 6u, 401 or greater 7u scheduled for administration at 8:00am, 12:00pm, 5:00pm, and 8:00pm.
-There was documentation Humalog was not administered according to the sliding scale for 10 of 124 opportunities between 0701/22 and 07/31/22.
-On 07/01/22 at 8:00am, FSBS was 129 and 1u

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of Humalog was documented as administered, but 0u should have been administered.
-On 07/01/22 at 12:00pm, FSBS was 200 and 2u of Humalog was documented as administered, but 1u should have been administered.
-On 07/07/22 at 5:00pm, FSBS was 232 and 0u of Humalog was documented as administered, but 2u should have been administered.
-On 07/11/22 at 12:00pm, FSBS was 210 and 1u of Humalog was documented as administered, but 2u should have been administered.
-On 07/17/22 at 8:00am, FSBS was 110 and 1u of Humalog was documented as administered, but 0u should have been administered.
-On 07/17/22 at 12:00pm, FSBS was 200 and 2u of Humalog was documented as administered, but 1u should have been administered.
-On 07/18/22 at 8:00pm, FSBS was 216 and 1u of Humalog was documented as administered, but 2u should have been administered.
-On 07/19/22 at 8:00am, FSBS was 124 and 1u of Humalog was documented as administered, but 0u should have been administered.
-On 07/30/22 at 8:00am, FSBS was 120 and 1u of Humalog was documented as administered, but 0u should have been administered.
-On 07/30/22 at 12:00pm, FSBS was 155 and 2u of Humalog was documented as administered, but 0u should have been administered.
-Resident #1's FSBS ranged from 33 to 405.

Review of Resident #1's eMAR for 08/01/22 through 08/16/22 revealed:
-There was an entry for Humalog 100/mL check and record FSBS with meals and at bedtime and inject per SSI: 160-200= 1u, 201-240= 2u, 241-280= 3u, 281-320= 4u, 321-360= 5u, 361-400= 6u, 401 or greater 7u scheduled for administration at 8:00am, 12:00pm, 5:00pm, and 8:00pm.

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-There was documentation Humalog was not administered according to the sliding scale for 3 of 61 opportunities between 08/01/22 and 08/16/22.
-On 08/04/22 at 12:00pm, FSBS was 155 and 1u of Humalog was documented as administered, but 0u should have been administered.
-On 08/08/22 at 5:00pm, FSBS was 169 and 6u of Humalog was documented as administered, but 1u should have been administered.
-On 08/014/22 at 12:00pm, FSBS was 200 and 2u of Humalog was documented as administered, but 1u should have been administered.
-Resident #1's FSBS ranged from 55 to 460.

Interview with a pharmacist at the facility's contracted pharmacy on 08/17/22 at 9:25am revealed:
-Resident #1 had an order for Humalog check and record FSBS with meals and at bedtime and inject per SSI: 160-200= 1u, 201-240= 2u, 241-280= 3u, 281-320= 4u, 321-360= 5u, 361-400= 6u, 401 or greater 7u.
-One vial of Humalog was dispensed to the facility on 05/17/22, 06/19/22, and 08/07/22.

Interview with Resident #1 on 08/17/22 at 5:20pm revealed:
-He was diabetic and received FSBS and insulin, but he did not know how many times a day.
-He was administered insulin most of the time, but there were times when he did not receive it.
-He used to be able to tell when his insulin was high or low, but he could not tell anymore.

Interview with the medication aide (MA) on 08/17/22 at 10:47am revealed:
-She administered medication to Resident #1 and checked his FSBS.
-She checked Resident #1's FSBS and

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administered Humalog according to his sliding scale.
-Resident #1 also had a scheduled dose of Humalog and she administered the sliding scale dose and the scheduled dose together; however, she documented both doses separately.
-She did not know she had made errors with administration of Resident #1's Humalog SSI.
-She thought she may have looked at the sliding scale incorrectly when the wrong number of units were documented for Resident #1's Humalog SSI.
-She did not know if anyone reviewed the eMARs for accuracy.

Interview with a second MA on 08/17/22 at 11:06am revealed:
-She administered insulin to Resident #1 and checked his FSBS.
-Resident #1 was the only Resident in the Special Care Unit (SCU) who was administered insulin and had SSI.
-She documented administration of Resident #1's SSI immediately after she administered it.
-She did not know she had errors with administration of Resident #1's Humalog SSI and no one told her she had made a mistake.
-She thought she made errors with administration of Humalog SSI because she looked at the sliding scale incorrectly before administering.

Interview with the Special Care Unit Coordinator (SCUC) on 08/17/22 at 12:14pm revealed:
-Resident #1 was administered Humalog SSI.
-She did not know there were errors with Resident #1's Humalog SSI administration.
-She did not know if the MAs were getting confused when they looked at the sliding scale.
-The MAs had diabetic care training.
-The Resident Care Director (RCD) was

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responsible for reviewing insulin administration on the eMAR and she helped, but she did not know how often.
-She had not reviewed Humalog SSI on Resident #1's eMARs.
-Resident #1 had not shown any signs of hyperglycemia or hypoglycemia.

Interview with the RCD on 08/17/22 at 4:12pm revealed:
-She was responsible for reviewing residents' eMARs, but she did not have a schedule; she reviewed them periodically and did not know when she last reviewed.
-She looked at Resident #1's SSI on his eMARs, but she did not remember when.
-She did not realize Resident #1 had errors in administration of his Humalog SSI.
-She thought the MAs could have had errors in documentation rather than administration.

Interview with a nurse from Resident #1's endocrinologist's office on 08/17/22 at 2:09pm revealed:
-Resident #1 had an order for sliding scale insulin (SSI) Humalog 100/mL check and record FSBS with meals and at bedtime and inject per SSI: 160-200= 1u, 201-240= 2u, 241-280= 3u, 281-320= 4u, 321-360= 5u, 361-400= 6u, 401 or greater 7u.
-The endocrinologist had not been notified of any errors with insulin administration.
-There could have been increased risks for Resident #1 receiving too much or too little Humalog depending on what his blood sugars were at the time of the FSBS check and what staff did to increase or lower blood sugar before or after his FSBS was taken.
-Resident #1 first visited the endocrinologist on 02/03/22 and his A1C (a test that measures

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average blood sugar levels) was 6.8 at that time.
-Resident #1's second visit to the endocrinologist was on 05/05/22 and his A1C was 6.7 at that time.
-There was no documentation of any other A1C labs obtained since 05/05/22.

Telephone interview with Resident #1's primary care physician (PCP) on 08/17/22 at 3:54pm revealed:
-Staff had reported to her when the FSBS was greater than 400 or less than 60, but she did not know Resident #1's Humalog SSI had been administered incorrectly.
-She would be in contact with Resident #1's endocrinologist regarding his Humalog SSI.
-She expected the MAs to administer Humalog SSI according to the sliding scale order.

Interview with the Administrator on 08/17/22 at 4:51pm revealed:
-She did not know Resident #1 had errors with administration of his Humalog SSI.
-She expected MAs to administer Humalog SSI according to the sliding scale.
-The RCD and the SCUC were responsible for reviewing Humalog SSI on Resident #1's eMAR to ensure accurate administration.

2. Review of Resident #4's current FL-2 dated 07/20/22 revealed:
-Diagnosis included diabetes type II, gout, chronic kidney disease stage III and basal cell carcinoma.
-There was an order for dicyclomine 20mg 2 times a day (used to treat stomach/intestinal cramps).

Review of Resident #4's physician's order sheet dated 07/27/22 revealed an order for dicyclomine 20mg 2 times a day, schedule: DAILY AT 08:00.

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D 358	Continued From page 16 Observation Resident #4's medications on hand on 08/17/22 at 11:45am revealed: -There was a punch card labeled dicyclomine 20mg 2 times a day dispensed 07/22/22 for 30 tablets and 5 remaining. -There was a second punch card labeled dicyclomine 20mg 2 times a day dispensed 08/05/22 for 60 tablet and 60 remaining, with initials written below the label. Review of Resident #4's electronic Medication Administration Record (eMAR) for 07/22/22-08/17/22 revealed: -An entry for dicyclomine 20mg 2 times a day, scheduled for administration at 8:00 am. -There was documentation of administration of dicyclomine 20mg at 8:00am from 07/22/22-/8/17/22. -There was no time entry to document a second dose of dicyclomine 20mg as ordered. -There was no documentation of administration for a second dose of dicyclomine 20mg from 07/22/22-/8/17/22. Based on the number of tablets administered from the cards, 25 from 07/22/22 at 8:00am to 08/17/22 at 8:00am, compared to the number that should have been administered, 53 leaving 37 remaining, there should not be 65 tablets remaining if administered correctly 2 times a day. Interview on 08/17/ at 11:50am with a medication aide (MA) revealed: -She had administered Resident #4's medication numerous times on first shift (7a-3p) . -Resident #4's medications are scanned and did not give a warning that his dicyclomine was scheduled 2 times a day. -She thought the pharmacy entered the orders in	D 358		

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the eMAR.
-She had not noticed that Resident #4's dicyclomine did not have a line to document for a second dose.
-The MAs dated and initialed the medication cards when they are checked in on cycle fill nights.
-The MAs were only checking that the medication was delivered, not that the label and eMAR matched.

Interview with a second MA on 08/17/22 at 11:55am revealed:
-The MA was not aware Resident #4 had not received the dicyclomine 2 times a day.
-She used the eMAR computer bar code scanner to administer scheduled medications this morning.
-The bar code scanner would not alert her, so she wouldn't have been prompted to double check the label and eMAR.
-She had not seen that Resident #4's dicyclomine did not have a place to document a second dose on the eMAR.

Interview with Resident #4 on 08/17/22 at 12:00pm revealed:
-He had a "short memory" but believed he took a pill for his stomach, but he was not sure of the name and how it was to be given.
-He had not had any trouble with his stomach or bowel movements since he came to live at the facility.
-He depended on the medication aides to administer his medications as the doctor had ordered.

Interview with the Special Care Unit Coordinator (SCUC) on 08/17/22 at 12:15pm revealed:
-Pharmacy entered orders on the eMAR for the

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facility once they receive an order.
-She and the Resident Care Director (RCD) performed eMAR audits against orders quarterly.
-Resident #4's would have been audited on his admission 07/22/22.
-The third shift (11p-7a) MAs check to see that ordered medications are delivered but not necessarily that the label and eMAR match.
-The MAs perform cart audits weekly, comparing medication punch cards to the eMAR.
-The last audit was completed 08/11/22 she believed.
-The facility's contracted pharmacy also performed their own cart audit.
-The facility's contracted pharmacy last audited the carts 08/12/22 but she did not know what their audit entailed.
-No one brought to her attention that Resident #4 did not have a place to document administration 2 times a day for his dicyclomine.
-Resident #4 had not had any stomach issues since he was admitted.

Telephone interview with a third MA on 08/17/22 at 2:37pm revealed:
-She usually worked second to third shift (7p-7a).
-Her initials on a resident's medication punch card indicates she check the medication against the eMAR when the pharmacy delivered it.
-She printed every resident's eMAR and compared it to the medication punch card labels.
-She checked in Resident #4's medications but did not remember seeing that his eMAR did not have an 8:00pm slot to document a second dose of his dicyclomine.
-She did not remember giving Resident #4 dicyclomine on second shift.
-She would not have been prompted by the eMAR that it was time for a second dicyclomine dose because there was no slot to indicate it

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D 358	Continued From page 19 would be due. Telephone interview with the facility's contracted pharmacy on 08/17/22 at 2:47pm revealed: -Resident #4 had an order for dicyclomine 20mg 2 times a day and was dispensed 30 on 07/22/22 and 60 on 08/05/22. -Dicyclomine is used to treat stomach spasms mostly for irritable bowel syndrome. -The pharmacy entered the orders for Resident #4's dicyclomine but did not enter a slot for a second dose as ordered. -Resident #4's eMAR should have had an 8:00am and 8:00pm slot to document administration of his dicyclomine 20mg. -The pharmacy did audit carts for the facility, comparing each resident's medication punch card labels to eMARs. -The pharmacy did audit carts at the facility recently but Resident #4 not having a second slot to document administration of his dicyclomine was missed. -The facility had not contacted the pharmacy to enter a second dose slot for Resident #4's dicyclomine before today, 08/17/22. Interview with the Resident Care Director (RCD) on 08/17/22 at 3:35pm revealed: -She sent orders to the facility's contracted pharmacy and then compared the medication punch cards to the eMAR when it was delivered. -She did not notice that Resident #4 did not have a second dose slot to document administration of his dicyclomine. -Third shift MAs perform cart audits to see that medication punch cards have been delivered. -She had no report from the MAs that they did not have a place to document a second dose of Resident #4's dicyclomine. -Resident #4 had not had any stomach issues	D 358		

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D 358	Continued From page 20 since his admission and the Primary Care Provider (PCP) was going to order his dicyclomine for 1 time a day. Telephone interview with Resident #4's Primary Care Provider (PCP) on 08/17/22 at 3:55pm revealed: -Resident #4 was ordered dicyclomine 20mg 2 times a day for intestinal spasms, stomach pain. -She was informed by the RCD today, 08/17/22, that he had only been administered his dicyclomine 1 time a day. -He had not had any abdominal pain or bowel issues since his admission in July 2022. -She did not think he had any negative affects from only getting dicyclomine 1 time a day. -She expected all medications to be administered as ordered. Interview with the Administrator on 08/17/22 at 4:50pm revealed: -The RCD and SCUC were responsible to ensure the third shift (7p/11p-7a) MAs performed weekly cart audits. -Cart audits entailed comparing medication punch card labels to the resident's eMARs. -The MAs reported any discrepancies or missing medications to the RCD or SCUC to correct any issue. -She expected the cart and eMAR audits to be completed each week. -She expected all resident's medications to be administered as ordered.	D 358		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training	D 468		

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D 468	Continued From page 21 The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 6 staff (Staff C), who worked in the special care unit (SCU), completed the required 20 hours of training specific to the population served within the first 6 months of working in the special care unit. The findings are: Review of Staff C's, medication aide (MA)/	D 468		

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personal care aide (PCA), personnel record revealed:
-Staff C's date of hire was 07/12/21.
-There was documentation Staff C completed 6 hours of special care unit (SCU) orientation on 07/12/21.
-There was no documentation Staff C completed 20 additional hours of SCU training within the first 6 months from her date of hire.

Interview with Staff C on 08/17/22 at 2:45pm revealed:
-She worked primarily in the SCU since she was hired in July 2021.
-She remembered having SCU orientation when she was hired and completed some dementia training online, but she did not remember having 20 hours of SCU training within her first 6 months of hire.
-The Special Care Unit Coordinator (SCUC) or the Resident Care Director (RCD) were responsible for ensuring required trainings were completed.

Interview with the Business Office Manager (BOM) on 08/17/22 at 3:29pm revealed:
-She scheduled staff to complete 6 hours of SCU orientation during their orientation to the facility and prior to staff working on the floor.
-She thought staff had 1 year to complete the 20 hours of SCU training instead of 6 months.
-Staff C had not completed 20 hours of SCU training.
-She found 17 hours of SCU trainings for Staff C with the last training completed 03/24/22.

Interview with the RCD on 08/17/22 at 4:12pm revealed:
-She and the BOM worked together to ensure all trainings were completed for staff.

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D 468	Continued From page 23 -The SCUC was responsible for making sure the 20 hours of SCU training was completed for staff within 6 months of hire. -She did not know Staff C did not have 20 hours of SCU training completed. Interview with the SCUC on 08/17/22 at 5:46pm revealed: -Staff C worked in the SCU as a MA and PCA. -She knew 20 hours of SCU trainings were required within 6 months for staff working in the SCU. -She conducted dementia care trainings, but the RCD was responsible to let her know who required which trainings. -She did not know Staff C did not have 20 hours of SCU training completed. Interview with the Administrator on 08/17/22 at 4:51pm revealed: -The BOM and the RCD were responsible for ensuring required trainings were completed. -She had asked the BOM to conduct an audit of employee records randomly, but there was no schedule for auditing employee records. -She knew staff should have 20 hours of SCU training within 6 months of working in the SCU, but she did not know Staff C did not have her 20 hours after working in the SCU since 07/12/21.	D 468		
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		

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D935	Continued From page 24 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 record reviews and interviews, the facility failed to ensure 2 of 6 sampled staff who administered medication maintained documentation of a completed 5-hour, 10-hour, or	D935		

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D935	Continued From page 25	D935		

15-hour state approved medication training course (Staff A) and had successfully passed the written state medication administration examination (Staff E).

The findings are:

1. Review of Staff A's, medication aide (MA)/personal care aide (PCA), personnel record revealed:
-Staff A was hired by the facility on 11/01/19, but she had worked at the facility under different ownership since 2016.
-Staff A completed her medication clinical skills checklist on 04/20/16 and passed the written medication administration examination on 07/22/16.
-There was no documentation a 5-hour, 10-hour, or 15-hour medication training course had been completed.

Review of a resident's electronic Medication Administration Record (eMAR) for June 2022, July 2022, and August 2022 revealed:
-Staff A documented the administration of medications 12 days in June 2022.
-Staff A documented the administration of medications 10 days in July 2022.
-Staff A documented the administration of medications 10 days in August 2022 between 08/01/22 and 08/16/22.

Telephone interview with Staff A on 08/17/22 at 2:45pm revealed:
-She administered medications to residents during her shift and had been a MA since 2016.
-She thought she completed the 15-hour medication training course in 2018, but she was not sure.
-She did not have a certificate for the 15-hour

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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
D935	Continued From page 26	D935		

medication training.

Interview with the Business Office Manager (BOM) on 08/17/22 at 3:29pm revealed:
-The Resident Care Director (RCD) was responsible for ensuring the 5-hour, 10-hour, or 15-hour medication training was completed.
-She was responsible for maintaining employee records, but she did not keep track of what was needed for staff regarding medication trainings.
-The RCD gave her certificates for trainings once they were completed and she filed them.

Interview with the RCD on 08/17/22 at 4:12pm revealed:
-She and the BOM were responsible to work together to ensure all trainings were completed for staff including the 5-hour, 10-hour, or 15-hour medication training.
-Staff A worked for the facility under the previous ownership and she thought that Staff A had already completed 15 hours of medication training.
-She did not know if there was documentation that Staff A had completed 15 hours of medication training.

Interview with the Administrator on 08/17/22 at 4:51pm revealed:
-The BOM and the RCD were responsible for ensuring MAs had medication training and the BOM was responsible for maintaining staff records.
-She did not know if Staff A had completed a 5-hour, 10-hour, or 15-hour medication training.
-She did not know there was no documentation Staff A completed a 5-hour, 10-hour, or 15-hour medication training.
-The BOM periodically audited staff records to ensure staff were up to date with trainings, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034106	A. BUILDING: _____ B. WING _____	08/17/2022

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there was no set schedule and she did not know when staff records were last audited.

2. Review of Staff E's personnel file on 08/17/22 revealed:
-Staff E was hired on 11/01/19 in housekeeping but began training as a medication aide (MA) 05/13/22.
-There was no documentation Staff E had taken and successfully passed the medication aide examination.

Review of the facility's daily staff schedule for 08/16/22 and 08/17/22 revealed Staff E was scheduled as the medication aide for C hall for first shift (7a-3p).

Review of resident's July and August 2022 electronic Medication Administration Records (eMAR) revealed:
-Staff E signed the eMARs for medication administration on 07/22/22, 07/27/22-07/28/22, 08/01/22-08/07/22, 08/09/22-08/16/22.

Interview with Staff E on 08/17/22 at 3:10pm revealed:
-She was hired in 2019 in housekeeping and moved to a MA position in May 2022.
-She worked as a MA on first shift mostly on the special care unit (SCU).
-The Resident Care Director (RCD) usually told staff when training was due, but she did not know she was supposed to tell them she failed the medication aide examination.
-She failed the medication aide examination in the middle of July 2022 but could not recall the date.
-She did not inform the special care unit coordinator (SCUC), RCD or the Administrator that she had failed.

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D935	Continued From page 28 -She had administered medications up until today 08/17/22 when the RCD took her off the cart until she passed the medication aide examination. -She rescheduled her medication aide examination for 08/22/22. Interview with the Business Office Manager (BOM) on 08/17/22 at 3:29pm revealed: -She worked with the RCD to ensure MAs had their training and exams. -She received the certificates from the RCD or the staff and was responsible to file them. -She did not know when Staff E was scheduled for her exam and did not know she had failed. -The RCD would have kept track of MAs testing. Interview with the RCD on 08/17/22 at 4:15pm revealed: -She and the Business Office Manager (BOM) worked together to ensure all staff training/examination results are in personnel files. -She would give the BOM the certificates for staff's completed training to file. -She did not know Staff E failed her medication aide examination. -She thought MAs had an extension by the state to have more than 60 days to take their medication aide examination and so thought Staff E had more time to take the exam. Interview with the Administrator on 08/17/22 at 4:50pm revealed: -The RCD and BOM worked together to ensure staff training is in the personnel files. -The BOM was responsible to maintain the personnel files after staff were hired. -She did not have an audit plan but would just ask for random audits for staff training by the BOM and RCD. -The RCD believed MAs had an extension from	D935		

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D935	Continued From page 29 the state to allow longer for staff to take the medication aide examination. -She was not aware Staff E had failed the medication aide examination in July 2022. -She removed Staff E from the cart until she retakes the medication aide examination.	D935		