STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063020	A. BUILDING: _____ B. WING _____	01/27/2017

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ELMCROFT OF SOUTHERN PINES	101-115 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 01/26/17 and 01/27/17.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as prescribed to 1 of 5 sampled residents (Resident #5) ordered Aricept 10 mg daily (used to treat dementia). The findings are: Review of Resident #5's current FL2 dated 1/27/17 revealed: -A diagnosis of Alzheimers. -A physician's order for donepezil (Aricept) 10 mg daily. Review of Resident #5's record revealed: -A previous FL2 dated 11/11/15 with a physician's order for Aricept 10 mg daily. -A physician's order dated 1/25/17 for Aricept 10 mg daily at 6:00 pm. -A pharmacy review dated 11/09/16 documented "chart not on site, full review next visit.	D 358		

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D 358	Continued From page 1 Medications reviewed, no recommendations". Review of Resident #5's November 2016, December 2016, and January 2017 electronic Medication Administration Records (eMARs) revealed: -They were printed copies of eMARs. -An entry for Aricept 10 mg daily and scheduled to be administered at 6:00 pm. The printed copy of the eMAR had X marks for every other day from 11/01/16 to 1/31/17. -Aricept 10 mg was documented as administered every other day from 11/01/16 to 1/24/17. -There were blank boxes on the even days from 1/26/17 to 1/30/17 for days when the medication would be administered, and boxes with X marks from 1/25/17 to 1/31/17 to reflect days the medication would not be administered. Review of medications on hand on 1/27/17 at 11:30 am and available to be administered to Resident #5 revealed an Aricept 10 mg bottle labeled to be administered daily with 90 tablets dispensed on 1/05/17. Interview on 1/27/17 at 10:15 am with the Special Care Unit (SCU) Clinical Leader (CL) revealed: -She was a Licensed Practical Nurse (LPN). -She had been the SCU CL since October 2015. -Pharmacy entered medication orders into the eMAR if it was before 5:00 pm. If it was after 5:00 pm, the MA or the the SCU CL entered a 3 day temporary order into the system, that would become a permanent order after pharmacy verified the order. -When pharmacy entered an order into the eMAR, the facility was given a prompt to "accept/approve" it to make sure it was entered correctly. This had to be done before a medication could be administered.	D 358		

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-At the beginning of a new month, she looked at the eMARs to make sure the MARs were accurate and nothing was left off.
-She had not noticed that Resident #5's Aricept 10 mg was being administered every other day, since the written order that was visible on the eMAR screen listed it as daily.

Interview on 1/27/17 at 11:55 am with the facility's contracted Pharmacy's representative revealed:
-They provided eMAR assistance only for Resident #5, but did not provide Resident #5's medications.
-Orders were faxed or electronically sent to the pharmacy for entering into the eMAR system.
-Resident #5's order for Aricept 10 mg daily had an origination date of 11/09/15. The current active order was set to be administered daily at 6:00 pm.
-She did not see Aricept 10 mg scheduled every other day on her side of the system.
-She "just sent another prompt to the facility to approve the Aricept daily order, so maybe it will be fixed".

Attempted telephone interview on 1/27/17 at 12:10 pm with Resident #5's family member was not successful.

Telephone interview on 1/27/17 at 12:15 pm with Resident #5's physician revealed:
-Resident #5 was ordered Aricept 10 mg daily.
-She was not aware Resident #5 had been receiving Aricept 10 mg every other day since November 2016. (It was unknown at the time of the interview when the order was changed in the eMAR to every other day.)
-She "did not think that receiving Aricept 10 mg every other day would affect him (Resident #5), or make a difference in the long term. I will know in

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D 358	Continued From page 3	D 358		

about 4 weeks", if after taking the Aricept 10 mg daily would improve his behavior.
-She and Resident #5's family member had discussed whether to continue this medication in the future.
-She would "monitor him (Resident #5) and look into how long he had been getting Aricept 10 mg every other day".

Interview on 1/27/17 at 2:20 pm with a Medication Aide (MA) revealed:
-She had been a MA at the facility for 6 years.
-The pharmacy entered orders into the eMAR system.
-When an order was entered by the pharmacy into the eMAR, the facility received a prompt to approve the order entry. The MAs were to verify the entry after it was compared to the order on the resident's record. "If it was wrong, we were to click 'decline' and contact the pharmacy to change it."
-The facility staff were not able to make any changes to the eMAR system, including times and frequencies of administration.
-"When the Pharmacist reviewer comes, they have printed copies of the eMAR and their own computer for completing their review. They should have caught the Aricept order" entry error.
-When a medication was due to be administered, the medication "order" popped up on the eMAR screen to be selected and documented after it was administered to the resident. If a medication was not due, like an order for every other day, then the order would not appear on the screen, so the medication was not administered in error.
-She was not aware if there was a process to verify accuracy of MARs month to month.
-The facility went from paper MARs to eMARs around February 2015.
-Resident #5's Aricept 10 mg was listed to be

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D 358	Continued From page 4 administered daily in the eMAR system. Interview of 1/27/17 at 2:50 pm with Resident #5's pharmacy representative revealed a mail order dispense date of 11/18/16 for 90 tablets of Aricept 10 mg. Interview on 1/27/17 at 3:00 pm with the Pharmacist revealed: -She completed the Medication Regimen Review on 11/09/16. -During her review, she gathered resident records and the current printed copies of the eMARs. She looked at the last 3 months of physician orders and checked if they were on the MAR and if they were accurate. -The printed copies of the eMARs were sent from the pharmacy to be available at her visit to facility. -She was not aware of seeing any medication administration issues for Resident #5. -If medication administration issues had been identified during the review, they would have been included in the recommendations. -When she completed Resident #5's pharmacy review on 11/09/16, "I would have only had 8 days on the MAR" to review. -"I missed the Aricept", but the facility is another double check. "The facilities may be too accepting of pharmacy putting orders in" (to the eMAR system). Interview on 1/27/17 at 3:30 pm with the Executive Director (ED) revealed: -He had been the Resident Service Director before becoming the ED 1 and 1/2 years ago. -The facility went to the eMAR system the end of 2014. -He expected his staff to check all orders closely, and to administer medications as ordered. -The pharmacy review was completed quarterly	D 358		

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D 358	Continued From page 5 and was "another double-check" that medications were administered as ordered. -He was not aware of Resident #5's medication administration discrepancies. -He was made aware by staff today of Resident #5 being given Aricept 10 mg every other day instead of daily as ordered. He had looked into the eMAR records and found that "the pharmacy had changed the administration time to 6:00 pm on 10/06/16. When they did that, it was clicked to administer Q2D, meaning every other day. The order corrected today 1/27/17 was Q1D, meaning every day. Orders entered by our staff are all zeroes for the prescription number, so I can tell it was entered by the pharmacy." Review of a Medication Error Report dated 1/27/17 revealed Resident #5's physician was notified Aricept 10 mg daily order dated 11/09/16 was administered every other day from 11/09/16 until it was discovered and corrected in the eMAR system on 1/27/17.	D 358		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following:	D 400		

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D 400	Continued From page 6 (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the on-site medication review included the review of electronic Medication Administration Records (eMARs) to determine that medications were administered as prescribed to 1 of 5 sampled residents (Resident #5) ordered Aricept 10 mg daily (used to treat dementia). The findings are: Review of Resident #5's current FL2 dated 1/27/17 revealed: -A diagnosis of Alzheimers. -A physician's order for donepezil (Aricept) 10 mg daily.	D 400		

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D 400	Continued From page 7	D 400		

Review of Resident #5's record revealed:
-A previous FL2 dated 11/11/15 with a physician's order for Aricept 10 mg daily.
-A physician's order dated 1/25/17 for Aricept 10 mg daily at 6:00 pm.
-A pharmacy review dated 11/09/16 documented "chart not on site, full review next visit. Medications reviewed, no recommendations".

Review of Resident #5's November 2016, December 2016, and January 2017 eMARs revealed:
-They were printed copies of eMARs.
-An entry for Aricept 10 mg daily and scheduled to be administered at 6:00 pm. The MARs had X marks for every other day from 11/01/16 to 1/31/17.
-Aricept 10 mg was documented as administered every other day from 11/01/16 to 1/24/17.
-There were blank boxes on the even days from 1/26/17 to 1/30/17 for days when the medication would be administered, and boxes with X marks from 1/25/17 to 1/31/17 to reflect days the medication would not be administered.

Review of medications on hand on 1/27/17 at 11:30 am and available to be administered to Resident #5 revealed an Aricept 10 mg bottle labeled to be administered daily with 90 tablets dispensed on 1/05/17.

Interview on 1/27/17 at 10:15 am with the Special Care Unit (SCU) Clinical Leader (CL) revealed:
-She was a Licensed Practical Nurse (LPN).
-She had been the SCU CL since October 2015.
-Pharmacy entered medication orders into the eMAR if it was before 5:00 pm. If it was after 5:00 pm, the MA or the the SCU CL entered a 3 day temporary order into the system, that would become a permanent order after pharmacy

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verified the order.
-When pharmacy entered an order into the eMAR, the facility was given a prompt to "accept/approve" it to make sure it was entered correctly. This had to be done before a medication could be administered.
-At the beginning of a new month, she looked at the eMARs to make sure the MARS were accurate and nothing was left off.
-She had not noticed that Resident #5's Aricept 10 mg was being administered every other day, since the written order that was visible on the eMAR screen listed it as daily.

Interview on 1/27/17 at 11:55 am with the facility's contracted Pharmacy's representative revealed:
-They provided eMAR assistance only for Resident #5 but did not provide Resident #5's medications.
-Orders were faxed or electronically sent to the pharmacy for entering into the eMAR system.
-Resident #5's order for Aricept 10 mg daily had an origination date of 11/09/15. The current, active order was set to be administered daily at 6:00 pm.
-She did not see Aricept 10 mg scheduled every other day on her side of the system.
-She "just sent another prompt to the facility to approve the Aricept daily order, so maybe it will be fixed".

Telephone interview on 1/27/17 at 12:15 pm with Resident #5's physician revealed:
-Resident #5 was ordered Aricept 10 mg daily.
-She was not aware Resident #5 had been receiving Aricept 10 mg every other day since November 2016. (It was unknown at the time of the interview when the order was changed in the eMAR to every other day.)
-She "did not think that receiving Aricept 10 mg

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every other day would affect him (Resident #5), or make a difference in the long term. I will know in about 4 weeks", if after taking the Aricept 10 mg daily would improve his behavior.
-She and Resident #5's wife had discussed whether to continue this medication in the future.
-She would "monitor him (Resident #5) and look into how long he had been getting Aricept 10 mg every other day".

Interview on 1/27/17 at 2:20 pm with a Medication Aide (MA) revealed:
-She had been a MA at the facility for 6 years.
-The pharmacy entered orders into the eMAR system.
-When an order was entered by the pharmacy into the eMAR, the facility received a prompt to approve the order entry. The MA were to verify the entry after it was compared to the order on the resident's record. "If it was wrong, we were to click 'decline' and contact the pharmacy to change it."
-The facility staff were not able to make any changes to the eMAR system, including times and frequencies of administration.
-"When the Pharmacist reviewer comes, they have printed copies of the eMAR and their own computer for completing their review. They should have caught the Aricept order" entry error.
-When a medication was due to be administered, the medication "order" popped up on the eMAR screen to be selected and documented after it was administered to the resident. If a medication was not due, like an order for every other day, then the order would not appear on the screen, so the medication was not administered in error.
-She was not aware if there was a process to verify accuracy of MARs month to month.
-The facility went from paper MARs to eMARs around February 2015.

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D 400	Continued From page 10 -Resident #5's Aricept 10 mg was listed to be administered daily in the eMAR system. Interview of 1/27/17 at 2:50 pm with Resident #5's pharmacy representative revealed a mail order dispense date of 11/18/16 for 90 tablets of Aricept 10 mg. Interview on 1/27/17 at 3:00 pm with the Pharmacist revealed: -She completed the Medication Regimen Review on 11/09/16. -During her review, she gathered resident records and the current printed copies of the eMARs. She looked at the last 3 months of physician orders and checked if they were on the MAR and if they were accurate. -The printed copies of the eMARs were sent from the pharmacy to be available at her visit to facility. -She was not aware of seeing any medication administration issues for Resident #5. -If medication administration issues had been identified during the review, they would have been included in the recommendations. -When she completed Resident #5's pharmacy review on 11/09/16, "I would have only had 8 days on the MAR" to review. -"I missed the Aricept", but the facility is another double check. "The facilities may be too accepting of pharmacy putting orders in" (to the eMAR system). Interview on 1/27/17 at 3:30 pm with the Executive Director (ED) revealed: -He had been the Resident Service Director before becoming the ED 1 and 1/2 years ago. -The facility went to the eMAR system at the end of 2014. -He expected his staff to check all orders closely, and to administer medications as ordered.	D 400		

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D 400	Continued From page 11 -The pharmacy review was completed quarterly and was "another double-check" that medications were administered as ordered. -He was not aware of Resident #5's medication administration discrepancies or that the discrepancies were not identified by the consulting pharmacist during his last review. -He was made aware by staff of Resident #5 being given Aricept 10 mg every other day instead of daily as ordered. He had looked into the eMAR records and found that "the pharmacy had changed the administration time to 6:00 pm on 10/06/16. When they did that, it was clicked to administer Q2D, meaning every other day. The order corrected today 1/27/17 was Q1D, meaning every day. Orders entered by our staff are all zeroes for the prescription number, so I can tell it was entered by the pharmacy." Review of a Medication Error Report dated 1/27/17 revealed Resident #5's physician was notified Aricept 10 mg daily order dated 11/09/16 was administered every other day from 11/09/16 until it was discovered and corrected in the eMAR system on 1/27/17.	D 400		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be	D 468		

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D 468	Continued From page 12 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 observations, interviews, and review of personnel files, the facility failed to assure 2 of 3 sampled staff (A and B) who were responsible for personal care and supervision within the Special Care Unit (SCU) completed 20 hours of training specific to the population being served within 6 months of employment. The findings are: 1. Review of Staff A's personnel file revealed: -Staff A was hired as a Medication Aide (MA) on 6/11/15. -Staff A completed 6 hours of SCU orientation training upon hire. -She had documentation of 14.5 additional hours	D 468		

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D 468	Continued From page 13 of training specific to SCU per month between 6/20/16 and 12/03/16. -There was no documentation of any other training specific to the SCU population within 6 months of hire, from 6/11/15 through 12/11/15. Interview on 1/26/17 at 4:11 pm with Staff A revealed: -She worked in both the Assisted Living (AL) and the SCU and functioned as a MA. -She tried to take all training offered by the facility, but many of the trainings were offered around 2:30 pm and she could not leave her role as a MA to attend the classes. -She was unaware the staff of the SCU involved with personal care and supervision were required to have 20 hours of training in the first 6 months of hire. -She did not know how many hours of training she had, but thought they offered 1-2 hours of training a month. Refer to interview with the Business Office Manager (BOM) on 1/27/17 at 11:08 am. Refer to interview with the Training Development Coordinator on 1/27/17 at 3:08 pm revealed: Refer to interview Executive Director on 1/27/17 11:15 am. 2. Review of Staff B's personnel file revealed: -Staff B was hired as a Medication Aide (MA) on 7/08/13. -Staff B completed 6 hours of Special Care Unit (SCU) orientation training upon hire. -She had documentation of 4 additional hours of training specific to the SCU population each month from 7/08/13 through 1/08/14. -There was no documentation of any other	D 468		

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D 468	Continued From page 14 training specific to the SCU population within 6 months of hire, from 7/08/13 - 01/08/14. Interview on 1/27/17 at 3:25 pm with Staff B revealed: -She worked in both the AL and the SCU and for approximately 3 and 1/2 years. -She did not remember how much dementia training she had taken. -She did remember when she was hired she watched many videos related to the SCU population. -She was unaware the staff of the SCU involved with personal care and supervision were required to have 20 hours of training in the first 6 months of hire. -She did not know how many hours of training she had but the facility offered frequent trainings but they were not always based on the SCU population. Refer to interview with the Business Office Manager (BOM) on 1/27/17 at 11:08 am. Refer to interview with the Training Development Coordinator on 1/27/17 at 3:08 pm revealed: Refer to interview Executive Director on 1/27/17 11:15 am. _____ Interview on 1/27/17 at 11:08 am with the BOM revealed: -She was unaware staff needed 20 hours of SCU training hours within six months of employment. -There was no system in place to ensure that all the required education requirements were completed and in the employee records. -The Training Development Coordinator was responsible for ensuring all employee training was complete.	D 468		

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D 468	Continued From page 15 -The Training Development Coordinator had been on leave and in her absence she tried to ensure training was complete. Interview with the Training Development Coordinator on 1/27/17 at 3:08 pm revealed: -She had been on leave for about two years and had returned to work about a month ago. -She was unaware that staff working in the SCU were required to have 6 hours of training related to the SCU population within the first week of hire. -She was unaware that staff working in the SCU were required to have an additional 20 hours of training related to the SCU population within the first 6 months of hire. -She ensured monthly training was completed by staff related to SCU training on the corporate computerized training. -She did not audit the employee files upon her return to work. Interview on with the Executive Director on 1/27/17 at 11:15 am revealed: -The BOM and the Training Development Coordinator were responsible for ensuring all staff training was complete. -He was aware of the SCU training requirements. -He was not aware that the SCU staff had not completed the required training.	D 468		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory,	D934		

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D934	Continued From page 16 annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 4 sampled Medication Aides (Staff A, B and D) had received annual in-service training on infection control, safe practices for injections, and glucose monitoring. The findings are: A. Review of Staff A's personnel record revealed: -Staff A was hired as a Medication Aide (MA) on 6/11/15. -There was documentation Staff A had corporate based computerized infection control training dated 1/19/17. -There was documentation Staff A had training on bloodborne pathogens dated 8/05/15. -There was no documentation Staff A completed the annual mandatory infection control training. Interview on with Staff A on 1/27/17 at 4:11 pm revealed: -She had training on bloodborne pathogens at this facility but did not know when. -She had taken infection control classes on the computerized program offered by the corporate	D934		

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D934	Continued From page 17 office. -She thought she took the computerized training on infection control recently. -She had not taken an infection control class with a licensed trainer. -She was unaware of the annual mandatory infection control class. Refer to interview with the Business Office Manager (BOM) on 1/27/17 at 11:08 am. Refer to interview with the Training Development Coordinator on 1/27/17 at 3:08 pm. Interview with the Resident Services Director (RSD) on 1/27/17 at 3:36 pm Refer to interviews Executive Director on 1/27/17 at 12:15 pm and 2:56 pm. B. Review of Staff B's personnel record revealed: -Staff B was hired as a MA on 7/08/13. -There was no documentation Staff B completed the required annual infection control training. Interview with Staff B on 1/27/17 at 2:25 pm revealed: -She did have an infection control class with an instructor the first year she was hired but not annually. -She took the computerized training on infection control but could not recall when. -She did not think she had infection control training within the last year. -She was unaware of a mandatory annual infection control class. Refer to interview with the Business Office Manager (BOM) on 1/27/17 at 11:08 am.	D934		

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D934	Continued From page 18 Refer to interview with the Training Development Coordinator on 1/27/17 at 3:08 pm. Interview with the Resident Services Director (RSD) on 1/27/17 at 3:36 pm Refer to interviews Executive Director on 1/27/17 at 12:15 pm and 2:56 pm. C. Review of personnel records for Staff D, Medication Aide (MA) revealed: -A hire date of 01/29/16 as a MA. -No documentation of the annual mandatory infection control training course. Interview on 01/27/17 at 2:41 pm with Staff D revealed: -She had completed infection control training on a previous job, but had not completed the infection control course at this facility. -She was not aware there was a specific mandatory infection control course and had not been informed by facility that she needed to complete one. Refer to interview with the Business Office Manager (BOM) on 1/27/17 at 11:08 am. Refer to interview with the Training Development Coordinator on 1/27/17 at 3:08 pm. Interview with the Resident Services Director (RSD) on 1/27/17 at 3:36 pm Refer to interviews Executive Director on 1/27/17 at 12:15 pm and 2:56 pm. _____ Interview with the Business Office Manager (BOM) on 1/27/17 at 11:08 am. -She was not aware MAs and supervisors were	D934		

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D934	Continued From page 19	D934		

required to take the annual mandatory infection control training.
-There was no routine system in place to ensure that all of the education requirements were complete and in the employee records.
-The facility offered infection control training on the corporate computerized training, but she did not regularly track who took the training and who did not.

Interview with the Training Development Coordinator on 1/27/17 at 3:08 pm revealed:
-She had been on leave for about two years and had returned to work about a month ago.
-She was now responsible for ensuring all required training was completed by facility staff.
-She was not aware of the mandatory annual infection control training.
-They offered standardized training about personal protective equipment and bloodborne pathogens.

Interview with the Resident Services Director (RSD) on 1/27/17 at 3:36 pm revealed:
-She was aware that infection control training was mandatory.
-She was not aware there were staff members that lacked this training.
-It was collectively the responsibility of the BOM and the Training Development Coordinator to ensure staff had the mandatory infection control training.
-She acknowledged the role of the RSD included being the person responsible for the facility's infection control program, but did not "look into what this all entailed".

Interviews Executive Director on 1/27/17 at 12:15 pm and 2:56 pm revealed:
-The Resident Services Director (RSD) was the

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D934	Continued From page 20 designated staff person responsible for oversight of the facility's infection control program. -He was not aware there was a mandatory infection control course required for Medication Aides. -The BOM and the Training Development Coordinator were responsible for scheduling infection control training. -According to discussion with the BOM and the Training Development Coordinator, the last infection control training was "over a year ago" and they were unable to locate documentation of that training. -The BOM and the Training Development Coordinator were downloading the course from the website now and all Medication Aides had been called today and informed they would not administer any further medications until they completed the class.	D934		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration.	D935		

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D935	Continued From page 21 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 3 sampled Medication Aides (Staff A and D) hired after October 2013 had worked as a Medication Aide (MA) during the previous 24 months in an adult care home or successfully completed the 15-hour MA training. The findings are: A. Review of Staff A's personnel record revealed: -Staff A was hired as a MA on 6/11/15. -Documentation Staff A passed the written Medication Aide exam on 2/09/15.	D935		

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D935	Continued From page 22 -Documentation of a Medication Clinical Skills validation dated 7/30/15. -Documentation of the 10 hour medication training. -No documentation of an employment verification that Staff A had worked as a MA during the previous 24 months. -No documentation of the additional 5 hour MA training. Interview with Staff A on 1/27/17 at 4:11 pm revealed: -She had been a MA for almost two years. -She was not aware of the 5-10-15-hour MA training requirement. -She had had completed some the MA training. -She did remember taking a class upon hire and thought it was the 10 hour MA training. -She did not take a second MA training since her date of hire. Refer to interview with the Training Development Coordinator on 01/27/17 at 3:08 pm. B. Review of personnel records for Staff D, Medication Aide (MA), revealed: -A hire date of 01/29/16 as a MA. -Documentation Staff D passed the MA written examination on 02/25/07. -Documentation of a Medication Clinical Skills validation dated 02/05/16. -No documentation of a MA Employment Verification. -No documentation of 5-hr, 10-hr, or 15-hr MA training. Interview on 01/27/17 at 2:41 pm with Staff D revealed:	D935		

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D935	Continued From page 23 -She was not aware of the 5-10-15-hour MA training requirement. -She had not completed the 5-10-15-hour MA training. Refer to interview with the Training Development Coordinator on 01/27/17 at 3:08 pm. Interview with the Training Development Coordinator on 1/27/17 at 3:08 pm revealed: -She had been on leave for about two years and had returned to work about a month ago. -She was now responsible for ensuring all required training was completed by facility staff. -She was aware of 5 hours of medication training for new MAs, but was not aware of the additional 10 hours of training required until about two weeks ago. -During the hiring process for another MA "about two weeks ago", the Business Office Manager found the MA Verification Form and forwarded the form to her to begin using. -She did not audit the other MA personnel records to ensure the requirements were met because she became aware of the requirement just prior to being out on leave for two weeks and "just came back this week".	D935		