

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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 and complaint investigation on 6/30/15 - 7/01/15.	D 000		
D 137	<p>10A NCAC 13F .0407(a)(5) Other Staff Qualifications</p> <p>10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 2 of 3 sampled staff (Staff B and C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire according to G. S. 131E-256. The findings are:</p> <p>1. Review of the Medication Aide personnel record for Staff B revealed: - She was hired to work at the facility on 6/09/15. - There was no documentation the HCPR had been checked prior to hire in Staff B's personnel record.</p> <p>Staff B was unavailable for interview.</p> <p>Interview with the facility's Co-Administrator on 7/1/15 at 11:00am revealed: - Staff B had been employed at the facility since 6/9/15. - The Co-Administrator did not know if HCPR check was done upon hire if confirmation of</p>	D 137		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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 137	Continued From page 1 check was not in the employee's personnel file. 2. Review of the Medication Aide personnel record for Staff C revealed: - She was hired to work at the facility on 3/26/09. - There was no documentation the HCPR had been checked prior to hire in Staff C's personnel record. Staff C was unavailable for interview. Interview with the Medication Aide/ Supervisor on 7/1/15 at 12:15pm revealed: - Staff C had been employed at the facility since 2009. - A lot of her staff qualifications and training paperwork were located outside of the facility in storage.	D 137		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to implement physician orders for 1 of 3 Residents (Resident	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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 276	<p>Continued From page 2</p> <p>#1) sampled for thromboembolic disease hose (TED hose).</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 3/25/2015 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included Pick's dementia and mood disorder. -Resident is incontinent of bowel and bladder. -Resident is a wanderer. -Resident requires personal care assistance with all activities of daily living to include bathing, feeding, and dressing. -Resident #1 requires the supervision provided by a Special Care Unit. <p>Review of the Resident Registry revealed Resident #1 was admitted to the facility on 9/15/2011.</p> <p>Review of the Concerns from Facility form revealed:</p> <ul style="list-style-type: none"> -Facility staff documented Resident #1 had swelling in right foot on 5/05/2015. -The form was faxed to resident's physician on 5/05/2015. <p>Review of Resident #1's record revealed:</p> <ul style="list-style-type: none"> -Resident #1 was transported to the physician's office for evaluation on 5/06/2015. -Signed physician order for TED hose and "keep leg elevated" dated 5/06/2015. -A deep vein thrombosis (DVT) study had been done with negative results. <p>Observation on 6/30/2015 at 11:00 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 sitting in wheelchair in the common area of facility. -Resident was dressed in clothes appropriate for 	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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 276	<p>Continued From page 3</p> <p>season.</p> <ul style="list-style-type: none"> -Resident had on socks and shoes. -Resident did not have on TED hose. <p>Interview with the Transportation/Resident Care Assistant (T/RCA) on 6/30/15 at 3:45 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 is total care. -Resident does not wear special hose or socks. <p>Observation of Resident #1 on 6/30/2015 at 4:02 p.m. revealed:</p> <ul style="list-style-type: none"> -The T/RCA checked Resident's brief. -Resident was clean and dry. -Resident did not have on TED hose. -Resident had on shoes and green colored socks <p>Observation of Resident #1 on 7/01/2015 at 8:16 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 was sitting in wheelchair in common area of facility. -Resident was dressed in a hospital gown. -Resident #1 had on socks and shoes. -Resident did not have on TED hose. <p>Interview with 3rd shift Medication Aide (MA) on 7/01/2015 at 8:30 a.m. revealed:</p> <ul style="list-style-type: none"> -The MA had knowledge of one facility Resident who wears TED hose. -First shift staff are responsible for putting on resident's TED hose. -Resident #1 does not wear TED hose. <p>Interview with the Medication Aide/Supervisor on 7/01/2015 at 9:30 a.m. revealed:</p> <ul style="list-style-type: none"> -Medication Aides are responsible for transcribing physician orders to the resident's Medication Administration Records (MARs). -It is facility procedure to make three copies of physician orders: one copy is placed in the 	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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 276	<p>Continued From page 4</p> <p>resident record; one copy is given to the MA to be faxed to the pharmacy and transcribed to the MAR; the final copy is given to the Resident Care Coordinator (RCC).</p> <ul style="list-style-type: none"> -The RCC is responsible for verifying that physician orders are processed and initiated. -The facility RCC has been out of work on medical leave since the first week of June 2015. -The Medication Aide/Supervisor identified three facility residents who wear TED hose. -The first shift Nursing Assistant (NA) assigned to the resident's hall is responsible for ensuring the resident's TED hose are put on each morning. -The second shift NA assigned to the resident's hall is responsible for removing resident's TED hose at bedtime or per physician order. -Resident #1 does not have TED hose and does not wear TED hose. -The Medication Aide/Supervisor was not aware that Resident #1 had a physician order for TED hose. <p>Observation and Interview with first shift MA on 7/01/2015 at 9:50 a.m. revealed:</p> <ul style="list-style-type: none"> -It is facility procedure that physician orders are transcribed to the MARs. -Three copies are made of physician orders: one copy is given to the MA to transcribe to the MAR; one copy is placed in the resident record; one copy is given to the RCC. -The facility communicates physician orders by faxing the orders to the pharmacy. -The RCC is supposed to ensure physician orders are processed and administered. -The Medication Aide/Supervisor and MA reviewed Resident #1's record. -The Medication Aide/Supervisor and MA discussed the order for Resident #1's TED hose was "missed." -The MA said that the T/RCA had initialed the 	D 276		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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 276	<p>Continued From page 5</p> <p>bottom of the physician order as documentation that the order was put in Resident #1's record and a copy of the order was given to the MA.</p> <ul style="list-style-type: none"> -The Medication Aide/Supervisor and MA communicated the process for transcription of physician orders and discussed that the RCC makes sure physician orders are carried out. <p>Interview with a Resident Care Assistant (RCA) on 7/01/2015 at 10:00 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 does not have TED hose. -Resident #1 does not wear TED hose. <p>Interview with the T/RCA on 7/01/2015 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> -The T/RCA is responsible for documenting the resident's name, physician's name, date of physician visit, and reason for physician visit on the Resident's Office Visit Record form. -It is facility procedure that the T/RCA copy the physician orders after returning the resident to the facility from an outside appointment. -The T/RCA is expected to put the original physician order in the resident's record and give a copy of the order to the MA. -The T/RCA recalled taking Resident #1 to the physician appointment on 5/06/2015. -The T/RCA recalled the physician mentioning an order for TED hose on 5/06/2015. -Upon return to facility on 5/06/2015, the T/RCA copied the physician order and gave the copy to the MA. <p>The T/RCA initialed the bottom of the order beside "Copy to SCC" to document the task was completed.</p> <ul style="list-style-type: none"> -The T/RCA reports thinking SCC meant MA. -The T/RCA put the original physician order in Resident #1's record and initialed the bottom of the order beside "Original in Chart" to document the task was completed. 	D 276		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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 276	<p>Continued From page 6</p> <p>Observation of the Medication/Aide/Supervisor on 7/01/2015 at 1:08 p.m. revealed the Medication Aide/Supervisor stated to the Owner/Administrator and Facility Consultant/Owner "We didn't see the order in the chart."</p> <p>Telephone interview with Resident #1's family member on 7/01/2015 at 11:35 a.m. revealed the family member had no knowledge that resident had a physician order for TED hose.</p> <p>Interview and observation with Owner/Administrator and Facility Consultant/Owner on 7/01/2015 at 1:15 p.m. revealed:</p> <ul style="list-style-type: none"> -When a resident is brought back to the facility from an outside appointment, it is the transporters responsibility to make a copy of the physician orders for the RCC. -The RCC and MAs are expected to discuss the physician orders and make sure the orders are faxed to the pharmacy and transcribed on to the MAR. -The RCC and MAs are responsible for implementing physician orders and clarifying orders in question. -The RCC was out of work on medical leave. -Resident #1 does not have TED hose. -Upon review of the physician order dated 5/06/2015, the Facility Consultant/Owner noted there were no staff initials at the bottom of the order indicating the order was faxed to the pharmacy. -The physician order was difficult to read because the writing was illegible: "It looks like DVT and TED hose but how would you know if you don't clarify it?" -The RCC should have clarified the physician 	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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 276	<p>Continued From page 7</p> <p>order when she received a copy of it.</p> <p>Telephone interview with physician on 7/01/2015 at 10:58 a.m. revealed: -The facility is expected to implement physician orders. -The facility is responsible for faxing physician orders to the pharmacy. -Resident #1 was evaluated by the physician again after 5/06/2015 and the edema was resolved.</p> <p>Interview with the Medication Aide/Supervisor on 7/01/2015 at 1:35 p.m. revealed: -The physician order for TED hose dated 5/06/2015 was clarified on 7/01/2015. -The facility had been in contact with the pharmacy on 7/01/2015 regarding Resident #1's TED hose order. -The facility would measure Resident #1 for TED hose the following morning, 7/02/2015, and fax the measurements to the pharmacy.</p>	D 276		
D 468	<p>10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train</p> <p>10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training</p> <p>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</p>	D 468		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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 468	<p>Continued From page 8</p> <p>schedules regarding training achievement.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 2 of 3 sampled staff (Staff A and B) assigned to perform duties in the special care unit received 6 hours of orientation training (Staff B) within the first week of employment and 20 hours of training (Staff A) within six months of employment. The findings are:</p> <p>1. Review of the Medication Aide personnel record for Staff A revealed:</p> <ul style="list-style-type: none"> - She was hired to work at the facility on 9/20/13 as a nursing assistant. - No documentation of required 20 hour SCU training was in Staff A's personnel record. <p>Interview with the facility's Co-Administrator on 7/01/15 at 11:00am revealed:</p> <ul style="list-style-type: none"> - She did Staff A's 6 hour SCU training during her orientation, but did not do 20 hour training. 	D 468		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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 468	<p>Continued From page 9</p> <ul style="list-style-type: none"> - She would schedule Staff A's 20 hour training as soon as possible. <p>Interview with Staff A on 7/01/15 at 12:45am revealed she did not remember receiving the 20 hour SCU training.</p> <p>2. Review of the Medication Aide personnel record for Staff B revealed:</p> <ul style="list-style-type: none"> - She was hired to work at the facility on 6/09/15 as a personal care aide. - No documentation of required 6 hour special care unit (SCU) training was in Staff A's personnel record. <p>Interview with the facility's Co-Administrator on 7/01/15 at 11:00am revealed:</p> <ul style="list-style-type: none"> - She did not know if Staff B's 6 hour SCU training had been done during her orientation. - She would schedule Staff B's 6 hour training as soon as possible. <p>Staff B was not available for interview.</p>	D 468		
D934	<p>G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements</p> <p>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements</p> <p>(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, 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</p>	D934		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D934	<p>Continued From page 10</p> <p>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</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 1 (Staff C) sampled medication aides completed the state mandated annual infection control course. The findings are: Review of the Medication Aide personnel record for Staff C revealed:</p> <ul style="list-style-type: none"> - She was hired to work at the facility on 3/26/09. - There was no documentation of completion of the state mandated annual infection control course. <p>Staff C was unavailable for interview.</p> <p>Interview with the Medication Aide/ Supervisor on 7/1/15 at 12:15pm revealed:</p> <ul style="list-style-type: none"> - She was unable to find the infection control training for Staff C. - She was not sure if Staff C had taken the training. 	D934		
D992	<p>G.S.§ 131D-45 Examination and screening</p> <p>G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.</p> <p>(a) An offer of employment by an adult care home</p>	D992		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D992	<p>Continued From page 11</p> <p>licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure an examination and screening for presence of controlled substances was performed for 1 of 1 sampled staff (Staff B) who required pre-employment drug screening. The findings are:</p> <p>Review of the Medication Aide personnel record</p>	D992		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
--------------------	--	---------------	---	--------------------

D992	<p>Continued From page 12</p> <p>for Staff B revealed:</p> <ul style="list-style-type: none"> - She was hired to work at the facility on 6/09/15 as a personal care aide. - No documentation of pre-employment drug screening. <p>Interview with the facility's Administrator on 7/01/15 at 10:40am revealed:</p> <ul style="list-style-type: none"> - Pre-employment drug screening for Staff B had not been done. <p>Today he "set up everything" with a local medical provider for employee drug screening.</p> <ul style="list-style-type: none"> - All employees (including Staff B) who required drug screenings will receive drug screenings. 	D992		
------	--	------	--	--