

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ATRIA MERRYWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 PARK ROAD CHARLOTTE, NC 28209</b>
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D 000	Initial Comments  The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on September 2, 2015 with an exit conference via telephone on September 4, 2015.	D 000		
D 161	<p>10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks</p> <p>10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.</p> <p>This Rule is not met as evidenced by: Type B Violation</p> <p>Based on observations, record reviews and interviews, the facility failed to assure 3 of 3 staff (Staff A, B and C) were competency validated by a registered nurse (RN) by return demonstration prior to performing the required tasks for 4 of 4 residents (Residents #1, #2, #3, and #4) with orders for thromboembolism-deterrent (TED) hose, Tuba-grip stocking, or oxygen administration.</p> <p>The findings are:</p>	D 161		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 161	<p>Continued From page 1</p> <p>A. Review of Staff A's personnel record revealed: -She was hired on 04/14/15 as Personal Care Aide/Medication Aide (MA). -There was no documentation Staff A had completed a Licensed Health Professional Support (LHPS) skills validation.</p> <p>Interview on 09/02/15 at 6:03 am with Staff A, MA revealed: -She was hired at the facility on 04/14/15, but her first day working at the facility was 04/15/15. -Her duties included medication administration, putting on TED hose, and sometimes assisting residents with oxygen administration by helping to refill the tanks, putting on tubes, turning the machine on and making sure the oxygen machine was set. -Her first day of work at the facility the Resident Services Supervisor (RSS) showed her what type of services to provide for each resident. -No training had been provided related to oxygen administration, applying and removing TED hose since she started working at the facility. -She previously had training related to oxygen and TED hose when going to school to be a nursing assistant.</p> <p>Refer to interview with the Resident Services Supervisor (RSS) on 09/02/15 at 11:05 am.</p> <p>Refer to interview on 09/02/15 at 3:10 pm with the Resident Services Director (RSD).</p> <p>Refer to interview with a Medication Aide (MA) on 9/2/15 at 10:45 am.</p> <p>Refer to second interview with the RSD on 9/2/15 at 3:40 pm.</p> <p>Refer to interview with a second MA on 9/2/15 at</p>	D 161		

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D 161	<p>Continued From page 2</p> <p>4:13 pm.</p> <p>Refer to interview with a third MA on 9/2/15 at 6:10 pm</p> <p>B. Review of Staff B's personnel record revealed: -She was hired on 01/15/15 as Personal Care Aide/Resident Medication Aide (MA). -Staff B had completed a Licensed Health Professional Support (LHPS) skills validation 03/10/15. -The documentation was part of a checklist for facility protocol, duties and responsibilities. -The checklist documented oxygen therapy only. -The document did not show return demonstrations observed. -There was no documentation for TED hose as an LHPS task or validation by return demonstration.</p> <p>Interview on 09/03/15 at 8:42 am with Staff B, MA revealed: -She was hired earlier this year, but was unable to recall the exact date. -She mostly worked the third shift, and her duties mostly required medication administration. -She did not assist residents with oxygen because she worked the third shift and residents oxygen was already set-up when she started her shift. -She sometimes applied TED hose, but had not received any training at the facility. -When she first started working at the facility another MA showed the services to provide for each resident. -No one at the facility provided training with return demonstration related to applying TED hose and oxygen administration.</p> <p>Refer to interview with the Resident Services</p>	D 161		

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D 161	<p>Continued From page 3</p> <p>Supervisor (RSS) on 09/02/15 at 11:05 am.</p> <p>Refer to interview on 09/02/15 at 3:10 pm with the Resident Services Director (RSD).</p> <p>Refer to interview with a Medication Aide (MA) on 9/2/15 at 10:45 am.</p> <p>Refer to second interview with the RSD on 9/2/15 at 3:40 pm.</p> <p>Refer to interview with a second MA on 9/2/15 at 4:13 pm.</p> <p>Refer to interview with a third MA on 9/2/15 at 6:10 pm</p> <p>C. Review of Staff C's personnel record revealed:                      -Staff C was hired on 11/14/04, as housekeeper.                      -Staff C was hired as a Personal Care Aide/Medication Aide (MA) on 07/30/12.                      -Documentation Staff C completed a LHPS validation on 8/13/10, 11/25/10 and 2/23/13.                      -The documentation was part of a checklist for duties and responsibilities.                      -The checklist documented oxygen therapy only.                      -The document did not show return demonstrations observed.                      -There was no documentation for TED hose as an LHPS task or validation by return demonstration.</p> <p>Interview on 9/2/15 at 5:00 pm with Staff C, MA revealed:                      -She started working at the facility in 2000, and had worked in the Assisted Living Unit for 6 years.                      -She was unsure what the LHPS validation was.                      -She had been trained by the RSS and the previous RSD.                      -The training consisted of classroom, videos and</p>	D 161		

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D 161	<p>Continued From page 4</p> <p>then "we shadowed" with another personal care aide on the floor.</p> <p>-She had not conducted return demonstration with a nurse, just the staff that she had "shadowed" with who had watched her perform tasks like TED hose, bathing, dressing, and transfers.</p> <p>-She did assist residents with oxygen by moving the oxygen tubing for the residents and she plugged up the concentrators.</p> <p>-She was observed by the RSD when she was trained as a MA. The nurse watched her do a medication pass.</p> <p>Interview on 9/2/15 at 3:00 pm with the RSD revealed:</p> <p>-She was the RN and had worked at the facility for almost 1 year.</p> <p>-Staff C was originally hired as a housekeeper on 11/14/04 and then transitioned into the positions of PCA/MA on 7/30/12.</p> <p>-She had not provided LHPS validation training to Staff C.</p> <p>-She was responsible to ensure MAs had LHPS validation.</p> <p>-She had not validated Staff C for LHPS tasks oxygen and TED hose.</p> <p>Based on record review, observation and attempted interview on 09/02/15, it was determined that Resident #1 was not interviewable. Resident #1's LHPS task was TED hose.</p> <p>Interview on 09/02/15 at 3:18 pm with Resident #4 revealed:</p> <p>-She was ordered TED hose due to excessive swelling and irritation in her legs.</p> <p>-It was important that TED hose were applied daily to reduce swelling.</p>	D 161		

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D 161	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>-Due to arthritis and shoulder replacement she was unable to apply the TED hose herself.</li> <li>-Facility staff applied her TED hose in the morning (3rd shift).</li> <li>-Facility staff, on second shift took her TED hose off at bedtime.</li> <li>-She had worn the TED hose for several months (unable to recall the exact date started to wear TED hose).</li> </ul> <p>Refer to interview with the Resident Services Supervisor (RSS) on 09/02/15 at 11:05 am.</p> <p>Refer to interview on 09/02/15 at 3:10 pm with the Resident Services Director (RSD).</p> <p>Refer to interview with a Medication Aide (MA) on 9/2/15 at 10:45 am.</p> <p>Refer to second interview with the RSD on 9/2/15 at 3:40 pm.</p> <p>Refer to interview with a second MA on 9/2/15 at 4:13 pm.</p> <p>Refer to interview with a third MA on 9/2/15 at 6:10 pm</p> <hr/> <p>Interview on 09/02/15 at 11:05 am with the Resident Services Supervisor (RSS) revealed:</p> <ul style="list-style-type: none"> <li>-She had been with the facility for 14 years.</li> <li>-She was a PCA as well as a MA.</li> <li>-She was not a Registered Nurse (RN).</li> <li>-Currently, she trained staff to perform transfers, ambulation with assistive devices and anti-embolism stockings including staff return demonstration.</li> <li>-It was a facility requirement that residents ordered oxygen had to be able to manage their own oxygen.</li> </ul>	D 161		

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D 161	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>-She was unaware if that the part of the admission contract/agreement.</li> <li>-There was no assessment of residents ordered oxygen to ensure the residents had the cognitive ability to self-maintain their own oxygen administration and care for the equipment.</li> <li>-There was one resident that was ordered oxygen "as needed" when that resident needed his oxygen he told staff, they assisted with turning on the machine and putting the nasal cannula on the resident.</li> <li>-The RSS said that she was aware that an inadequate supply or proper care of oxygen equipment could case hypoxia or confusion, and that was a potential problem for residents that self-managed their own oxygen.</li> <li>-Staff did assist residents with putting on TED hose in the morning and taking them off at bedtime, but she did not realize that was part of the LHPS task and other training and documentation was required.</li> </ul> <p>Interview on 9/2/15 at 3:10 pm with the Resident Services Director (RSD) revealed:</p> <ul style="list-style-type: none"> <li>-She had worked at the facility for almost 1 year.</li> <li>-She was a RN.</li> <li>-She was responsible for training of new hires and current staff. The training consisted of classroom instruction with corporate "DVDs and videos".</li> <li>-She included LHPS validations with new hire orientation and during annual trainings.</li> <li>-She used a corporate orientation check list form which included all the training conducted and did not have a separate LHPS validation form to use for LHPS tasks.</li> <li>-She was not aware she needed to complete an LHPS validation on staff for tasks performed by staff.</li> <li>-She did not provide return demonstration on any</li> </ul>	D 161		

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D 161	<p>Continued From page 7</p> <p>tasks for new hires or current staff with the exception of MA training and observations of the medication pass.</p> <ul style="list-style-type: none"> <li>-The Resident Services Supervisor (RSS) was responsible for staff training for personal care tasks and conducted return demonstration with new staff on those tasks.</li> <li>-Any staff assigned to precept new hires on the floor would have conducted return demonstration of personal care tasks with the new hires.</li> <li>-RSS was not a nurse, but she was a PCA/MA.</li> <li>-The TED hose was not listed as a task on the corporate orientation check list form she used for new hires and current staff.</li> <li>-Oxygen use was a task listed on the corporate orientation check list form she used for new hires and current staff.</li> <li>-Oxygen therapy monitoring was not conducted by staff. The residents were responsible for monitoring their own oxygen therapy or it was monitored by an outside agency.</li> <li>-The outside agency was either home health or Hospice.</li> <li>-She was unsure how the agencies monitored the oxygen and equipment.</li> </ul> <p>Interview with a Medication Aide on 9/02/15 at 10:45 am revealed:</p> <ul style="list-style-type: none"> <li>-She did apply anti-embolism stockings and learned this task in nurses aide training prior to employment at this facility.</li> <li>-The RSD had not watched her apply them with return demonstration.</li> <li>-The RSS had watched her apply them with return demonstration.</li> <li>-She assisted residents with refilling their oxygen tanks and helped them apply the oxygen and cannula's if they needed the assistance.</li> <li>-The RSS showed her how the oxygen machines turned on and off and how to refill tanks.</li> </ul>	D 161		

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D 161	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-The RSD did not watch her applying oxygen and it was not a part of the medication check list that they went through.</li> <li>-There was no return demonstration of oxygen administration.</li> <li>-One resident would tell staff when he needed his oxygen and she would give him his cannula and turn on his machine.</li> <li>-The concentrator was already set on the liter flow he was on and she did not change the liter flow.</li> </ul> <p>Second interview with the Resident Service Director (RSD) 9/02/15 at 3:40 pm revealed:</p> <ul style="list-style-type: none"> <li>-She did help in teaching staff and training staff but she did not "check off" staff for competency.</li> <li>-The oxygen company managed all maintenance and cleaning of the residents' oxygen equipment.</li> <li>-She did not know how often the equipment company would clean or change out filters or when they changed out cannula's.</li> </ul> <p>Interview with a second MA on 9/02/15 at 4:13 pm revealed:</p> <ul style="list-style-type: none"> <li>-The RSD did not watch her applying oxygen and it was not a part of the medication check list.</li> <li>-She did not apply oxygen to a resident as a part of return demonstration for the RSD or RSS. She was unaware that oxygen cannula's should be changed or how often and assumed this was done on another shift.</li> <li>-Would assist residents with their oxygen if they needed it and the resident's would ask for assistance when they needed assistance.</li> <li>-She would help by putting the cannula in the nose and around the ears and turn on the machine.</li> <li>-She did not know what the dose of oxygen was or where to find this information.</li> <li>-She was unaware that the external filter on the</li> </ul>	D 161		

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D 161	<p>Continued From page 9</p> <p>oxygen concentrator should be cleaned or how often and assumed that the company who provided oxygen did this maintenance. -Was unable to describe signs of hypoxia but when one resident asks for oxygen he is sometimes pale, clammy and out of breath. -She did not change the liter flow on the concentrator.</p> <p>Telephone interview with a third MA on 9/02/15 at 6:10 pm revealed: -She did assist residents applying oxygen if they requested it. -She would also know to apply oxygen by paying attention to their breathing and if they were "gasping for air" she would apply cannula and turn the machine on. -She did assist with refilling tanks and assisting residents to change from portable cylinders to room concentrators. -She was taught about the oxygen by the RSS but did not demonstrate how to apply oxygen to the RSD.</p> <hr/> <p>The facility provided the following Plan of Protection: -Immediately the RSD will train all staff regarding LHPS tasks oxygen administration and TED hose with return demonstrations. -LHPS tasks will be added to the MARs for monitoring. -The RSD will assure ongoing competence of staff performing LHPS tasks quarterly.</p> <p>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 23, 2015.</p>	D 161		

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D 276 D 276	<p>Continued From page 10</p> <p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to assure documentation of treatments and implementation of orders for 3 of 4 sampled residents (Residents #1, #2, and #4) with physician's orders for thromboembolism-deterrent (TED) hose, Tuba-grip stockings, and oxygen administration.</p> <p>The findings are:</p> <p>A. Review of Resident #2's current FL-2 dated 4/30/15 revealed: -Diagnoses included dyspnea and hypoxia, chronic respiratory failure secondary to congestive diastolic heart failure, chronic pleural effusions with history of thoracentesis, atrial fibrillation, severe mitral regurgitation questionable pneumonia and deep vein thrombosis prophylaxis. -A physician's order for oxygen therapy 2 Liters/minute via nasal cannula.</p> <p>Review of Resident #2's record revealed a physician's order dated 5/04/15 for oxygen 2 L/min via nasal cannula continuously and resident</p>	D 276 D 276		

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D 276	<p>Continued From page 11</p> <p>may self manage.</p> <p>Review of Resident #2's record revealed a Functional Needs Service Plan dated 6/04/15 which documented, "Has oxygen but can completely manage own needs."</p> <p>Observation of Resident #2 in her room on 9/02/15 at 9:10 am revealed: -Resident #2 was in a recliner with a nasal cannula in place with oxygen set on 2 L/min. -An oxygen concentrator with a home fill compressor and two refillable oxygen cylinders in the resident's room.</p> <p>Review of Resident #2's July, August, and September 2015 Medication Administration Records (MARs) revealed oxygen administration was not entered onto the MARs.</p> <p>Interview with Resident #2 on 9/02/15 at 3:50 pm revealed: -She was on a continuous flow of oxygen since her hospitalization in April 2015, prior to her admission. -She had always been on oxygen while at this facility.</p> <p>Interview with the Resident Services Director (RCD) 9/02/15 at 11:05 am revealed: -They did have residents at the facility that were on oxygen. -The residents that had oxygen orders must self manage their own oxygen. -She did evaluate Resident #2's ability to self administer her own oxygen. -She was aware that Resident #2 knew how to apply her cannula and knew her liter flow. -She was aware that Resident #2 could not switch her tanks, remove and apply the regulator or refill</p>	D 276		

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NAME OF PROVIDER OR SUPPLIER  <b>ATRIA MERRYWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 PARK ROAD CHARLOTTE, NC 28209</b>
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D 276	<p>Continued From page 12</p> <p>her tanks.</p> <ul style="list-style-type: none"> <li>-Oxygen was not listed on the medication administration records because they were self-managed.</li> <li>-They did not utilize treatment administration records.</li> </ul> <p>Interview with Resident Service Supervisor (RSS) 9/02/15 at 11:05 am revealed:</p> <ul style="list-style-type: none"> <li>-Residents that were ordered oxygen must be able to manage their own oxygen per corporate policy.</li> <li>-Oxygen was not on the MARs because staff did not administer oxygen.</li> </ul> <p>Interview with a a Medication Aide on 9/02/15 at 4:13 pm revealed:</p> <ul style="list-style-type: none"> <li>-She would assist residents with their oxygen if they needed it and the residents would ask for assistance when they needed assistance.</li> <li>-She would help by putting the cannula in the nose and around the ears and turn on the machine.</li> <li>-She did not know what the dose of oxygen was or where to find this information.</li> <li>-She did not change the liter flow on the concentrator.</li> </ul> <p>B. Review of Resident #3's current FL2 dated 05/05/15 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included peripheral edema, rheumatoid arthritis, and hypertension.</li> <li>-No order for TED hose was on the FL2.</li> </ul> <p>Review of Resident #4's record revealed:</p> <ul style="list-style-type: none"> <li>-Resident was admitted to facility on 5/09/14.</li> <li>-No physician's order for TED hose (anti-embolism stockings) was in the resident's record.</li> </ul>	D 276		

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D 276	<p>Continued From page 13</p> <p>Review of Resident #4's July and August 2015 Medication Administration Record (MARs) revealed: -TED hose was not written on the MARs.</p> <p>Interview on 09/02/15 at 3:18 pm with Resident #4 revealed: -She had lived at the facility one and one-half years. -Facility staff put the TED on her every morning between 6:00 am and 7:00 am. -Facility staff on the second shift took the TED hose before she went to bed.</p> <p>Interview on 09/02/15 at 5:45 pm with two second shift Resident Service Aides/Medication Aide (MA) revealed: -Both staff said they had taken Resident #4's TED hose off before the resident went to bed. -They did not document removing the resident's TED hose.</p> <p>Interview on 09/02/15 at 4:48 pm with the Resident Services Director (RSD) revealed: -She was aware facility staff daily put TED hose on Resident #4 in the AM, and removed the TED hose at bedtime. -She did not realize documentation on the MAR was required for putting the TED hose on and taking them off. -She had not required or instructed staff to document the applying and removing of Resident #4's TED hose.</p> <p>C. Review of Resident #1's current FL2 dated 08/26/15 revealed: -Diagnoses included venous leg ulcer, dementia, and chronic kidney disease.</p> <p>Review of Resident #1's record revealed and</p>	D 276		

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D 276	<p>Continued From page 14</p> <p>order dated 07/24/15 revealed: -Resident #1 had an ulcer on her left leg. -Home health nurse was to treat the wound three times weekly. -The physician ordered Tuba-grip compression sleeve (hose/stocking) for the resident's left leg to wear when out of bed to control swelling.</p> <p>Review of Resident #1's record revealed no LHPS evaluation in the record.</p> <p>Review of Resident #1's July and August 2015 MARs revealed: -The resident's order for compression stocking on when out of bed control swelling was not documented on the MAR.</p> <p>Interview with the RSD on 09/02/15 at 4:48 pm revealed: -She was aware that Resident #1 had an order for compression stockings. -She was also aware if the resident removed the stocking that facility staff had to put the stocking back on. -She was unaware that MAR documentation needed to be done for related to the compression stockings being applied. -She had not instructed staff to document the applying of the Resident #1's compression stocking.</p> <p>Interview on 09/02/15 at 5:45 pm with two second shift Resident Service Aides/Medication Aide (MA) revealed: -Most days Resident #1 was confused. -The resident removed the compression stocking on her left leg, mostly at bed time. -Sometimes the resident just took the stocking off. -Staff were responsible for putting the</p>	D 276		

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D 276	Continued From page 15  compression stocking back on the resident. -She had not been instructed to document putting the resident's compression stocking back on Resident #1. -She was unaware documentation needed to be completed for doing this task.  Based on record review, observation and attempt interview on 09/02/15 it was determined that Resident #1 was not interviewable.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support  10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.	D 280		

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D 280	<p>Continued From page 16</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and records reviews, the facility failed to assure that a licensed health professional participated in the on-site review and completed a Licensed Health Professional Support (LHPS) assessment for 3 of 4 sampled residents (Residents #1, #2, #3, and #4) with orders for thromboembolism-deterrent (TED) hose, Tuba-grip stocking, and oxygen administration.</p> <p>The findings are:</p> <p>A. Review of Resident #2's current FL-2 dated 4/30/15 revealed: -Diagnoses included dyspnea and hypoxia, chronic respiratory failure secondary to congestive diastolic heart failure, chronic pleural effusions with history of thoracentesis, atrial fibrillation, severe mitral regurgitation questionable pneumonia and deep vein thrombosis prophylaxis.</p> <p>Observation of Resident #2 in her room on 9/02/15 at 9:10 am revealed: -Resident #2 was in a recliner with a nasal cannula in place with oxygen set on 2 Liters/minute. -An oxygen concentrator with a home fill compressor and two refillable oxygen cylinders in the resident's room.</p> <p>Review of Resident #2's Resident Register revealed an admission date of 05/01/15.</p> <p>Review of Resident #2's record revealed: -A physician's order dated 5/04/15 for oxygen 2 liters / minute via nasal cannula continuously and resident may self manage. -An oxygen equipment cleaning guideline that</p>	D 280		

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D 280	<p>Continued From page 17</p> <p>stated oxygen cannula's should be changed every three to four weeks and outside filters needed to be washed with warm water at least once a week and as needed.</p> <p>Review of Resident #2's LHPS assessment dated 5/4/15 revealed:                      -A current LHPS assessment completed by Resident Service Director (RN) with tasks listed for ambulation assistance, oxygen administration and monitoring as personal care tasks.                      -The LHPS assessment documented Resident #2 was on continuous oxygen at 2 liters / minute via nasal cannula and "Resident self manages her O2. Hospice manages Resident's care."                      -The LHPS assessment did not include documentation of the physical assessment of the types of oxygen delivery such as refillable cylinders, lung assessment, response to therapy, compliance with therapy or condition or maintenance of equipment.                      -The LHPS assessment did not address or include documentation of a physical assessment of Resident #2's ability to manipulate the oxygen regulator or manage the cylinders.                      -The LHPS assessment did not include documentation of an evaluation of the oxygen therapy or recommend changes to Resident #2's plan of care.                      -The LHPS did not include documentation of staff competency validation for oxygen administration.</p> <p>Review of Resident #2's LHPS assessment dated 8/13/15 revealed:                      -An LHPS assessment with tasks listed for ambulation assistance, oxygen administration and monitoring as personal care tasks.                      -The LHPS assessment documented Resident #2 was on continuous oxygen at 2 liters / minute via nasal cannula and "Resident self-manages her</p>	D 280		

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D 280	<p>Continued From page 18</p> <p>Oxygen".</p> <ul style="list-style-type: none"> <li>-The LHPS assessment did not include documentation of a physical assessment of types of oxygen delivery such as refillable cylinders, lung assessment, response to therapy, compliance with therapy or condition or maintenance of equipment</li> <li>-The LHPS did not include documentation of a physical assessment of Resident #2's ability to manipulate the oxygen regulator or manage the cylinders.</li> <li>-The LHPS did not include documentation of an evaluation of the oxygen therapy or recommend changes to Resident #2's plan of care.</li> <li>-The LHPS did not include documentation of staff competency validation for oxygen administration.</li> </ul> <p>Review of Resident #2's Care Plan dated 5/1/15 revealed:</p> <ul style="list-style-type: none"> <li>-Care plan did not address oxygen administration or self-administration of oxygen therapy.</li> <li>-No documentation of oxygen administration or that the resident self-administered oxygen.</li> </ul> <p>Review of Resident #2's records revealed oxygen administration was not documented as administered onto Medication Administration Records or Treatment Administration Records as having been administered or monitored.</p> <p>Interview with a Medication Aide on 9/02/15 at 10:45 am revealed:</p> <ul style="list-style-type: none"> <li>-She did apply anti-embolism stockings and learned this task in nurses aide training prior to employment at this facility.</li> <li>-She assisted residents with refilling their oxygen tanks and helped them apply the oxygen and cannula's if they needed the assistance.</li> <li>-One resident would tell staff when he needed his oxygen and she would give him his cannula and</li> </ul>	D 280		

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D 280	<p>Continued From page 19</p> <p>turn on his machine. -The concentrator was already set on the liter flow he was on and she did not change the liter flow.</p> <p>Interview with Resident #2 on 9/02/15 at 3:50 pm revealed: -The Resident had been living in the adjacent Independent Living and recently suffered a decline in health resulting in overall weakness which made it difficult for her to be as independent as she had been. -She did know how to place the cannula on her face. -She did know that she was on a 2 liter / minute oxygen flow. -She did not know how to refill the oxygen cylinders. -She did not know how to apply the regulator to the oxygen cylinder. -Staff refilled her oxygen cylinders and applied the regulator, and set the liter flow on the regulator. -She had extra cannula's in her closet but staff had not switched or replaced her cannula with a new one since her admission on 5/01/15. -She did not know there was an external filter that required cleaning and staff had not cleaned the external filter since her admission. -When staff helped her switch to the portable tank she would apply the portable nasal cannula to her face and the room concentrator nasal cannula would be left by staff on her walker, the bed and at times the floor. -She would call staff for assistance to change out tanks if the oxygen ran out.</p> <p>Interview with the Resident Service Director (RSD) 9/02/15 at 3:40 pm revealed: -The oxygen company managed all maintenance</p>	D 280		

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D 280	<p>Continued From page 20</p> <p>and cleaning of the residents' oxygen equipment. -She did not know how often the equipment company would clean or change out filters or when they changed out cannula's.</p> <p>Interview with a representative from the Durable Medical Equipment (DME) Company on 9/03/15 at 12:22 pm revealed: -Written guidelines for cleaning and up keep of oxygen equipment was given to each facility when equipment was delivered. -The DME company had one person designated to schedule maintenance on each oxygen concentrator that had been delivered. -DME staff services all concentrators every six months. -Servicing oxygen concentrators involved changing the internal filters and checking the hours of use. -Each 6 months service visit the DME company made included providing the next six months worth of oxygen cannula's. -All other routine maintenance such as cleansing the external filters weekly or changing out of cannula's was expected to be done by the client or those responsible for the client's care.</p> <p>Interview with a second MA on 9/02/15 at 4:13 pm revealed: -She was unaware that oxygen cannula's should be changed or how often and assumed this was done on another shift. -She would assist residents with their oxygen if they needed it and the resident's would ask for assistance when they needed assistance. -She would help by putting the cannula in the nose and around the ears and turn on the machine. -She did not know what the dose of oxygen was or where to find this information.</p>	D 280		

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D 280	<p>Continued From page 21</p> <ul style="list-style-type: none"> <li>-She was unaware that the external filter on the oxygen concentrator should be cleaned or how often and assumed that the company who provided oxygen did this maintenance.</li> <li>-She was unable to describe signs of hypoxia but when one resident asks for oxygen he is sometimes pale, clammy and out of breath.</li> <li>-She did not change the liter flow on the concentrator.</li> </ul> <p>Telephone interview with a third MA on 9/02/15 at 6:10 pm revealed:</p> <ul style="list-style-type: none"> <li>-She did assist residents applying oxygen if they requested it.</li> <li>-She would also know to apply oxygen by paying attention to their breathing and if they were "gaspng for air" she would apply cannula and turn the machine on.</li> <li>-She did assist with refilling tanks and assisting residents to change from portable cylinders to room concentrators.</li> </ul> <p>B. Observation on 09/02/15 at 10:10 am of Resident #4 revealed:</p> <ul style="list-style-type: none"> <li>-The resident was sitting in a recliner chair, in her apartment.</li> <li>-The resident had TED hose on both legs.</li> <li>-The resident's legs were not puffy or swollen.</li> <li>-The TED hose were applied correctly, they were even with no wrinkles, lines or creases.</li> </ul> <p>Review of Resident #4's current FL2 dated 05/05/15 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included peripheral edema, rheumatoid arthritis, and hypertension.</li> <li>-No order for TED hose was on the FL2.</li> </ul> <p>Review of Resident #4's record revealed:</p> <ul style="list-style-type: none"> <li>-Resident was admitted to facility on 5/09//14.</li> </ul>	D 280		

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D 280	<p>Continued From page 22</p> <p>-No physician's order for TED hose (anti-embolism stockings) was in the resident's record.</p> <p>1. Review of the Licensed Health Professional Support (LHPS) evaluations dated 05/14/15 and 08/13/15.</p> <p>-The report was prepared by Resident Services Director (RSD), who was an RN.</p> <p>-Applying and removing TED hose was not checked as an LHPS task.</p> <p>Interview on 09/02/15 at 3:18 pm with Resident #4 revealed:</p> <p>-She had lived at the facility one and one-half years.</p> <p>-She was wearing TED hose prior to her admission to the facility.</p> <p>-She previously had severe swelling in lower legs and feet with soreness.</p> <p>-She went to the hospital and upon discharge was ordered the TED hose to prevent swelling.</p> <p>-Due to her arthritis she was unable to put the TED hose on herself.</p> <p>-Facility staff put the TED her every morning between 6:00 am and 7:00 am.</p> <p>-Facility staff on the second shift took the TED hose before she went to bed.</p> <p>-Facility staff had assisted her with applying and removing the TED hose since her admission to the facility.</p> <p>-She knows who the RSD is, but the RSD had not had any conversations or mentioned completing an assessment or evaluation related to her TED hose since her admission to the facility.</p> <p>Interview on 09/02/15 at 5:45 pm with two second shift Personal Care Aides/Medication Aide (MA) revealed:</p> <p>-Both staff said Resident #4 had TED hose for six</p>	D 280		

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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
D 280	<p>Continued From page 23</p> <p>months or longer, they were unable to recall exactly when.</p> <ul style="list-style-type: none"> <li>-Both staff said the resident was unable to apply and remove her own TED hose and required staff assistance.</li> <li>-Both staff said they had taken Resident #4's TED hose off before the resident went to bed.</li> </ul> <p>Interview with a first shift MA on 9/02/15 at 10:45 am revealed:</p> <ul style="list-style-type: none"> <li>-She had been a MA since April, 2015.</li> <li>-She did apply anti-embolism stockings and learned this task in nurse's aide training prior to employment at this facility.</li> <li>-The RSD had not watched her apply them with return demonstration.</li> <li>-The RSS had watched her apply TED hose with return demonstration.</li> </ul> <p>2. Review of the LHPS evaluation dated 05/14/15 and 08/13/15.</p> <ul style="list-style-type: none"> <li>-The report was prepared by the PCA.</li> <li>-The resident was assessed as needing help with ambulation using an assistive device that requires physical assistance.</li> <li>-The nurse documented "Resident ambulates short distances with walker."</li> <li>-The LHPS evaluation did not include the type of help required (1 person stand assist) using the assistive device, frequency of staff assistance, resident response to ambulation, the resident's progress to care provided, or recommendation, if any, for changes in the care of the resident.</li> </ul> <p>Interview on 09/02/15 at 5:45 pm with two second shift Personal Care Aides/Medication Aide (MA) revealed:</p> <ul style="list-style-type: none"> <li>-Resident #4 was a one person assist.</li> <li>-Resident #4 was able to ambulate with staff assistance.</li> </ul>	D 280		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2015</b>
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D 280	<p>Continued From page 24</p> <ul style="list-style-type: none"> <li>-Staff had to assist Resident #4 with standing (1-person).</li> <li>-The resident was able to walk independently, if she took her time walking.</li> </ul> <p>3. Review of the LHPS evaluation dated 05/14/15 and 08/13/15.</p> <ul style="list-style-type: none"> <li>-The report was prepared by RSD.</li> <li>-The resident was assessed as needing help with physical therapy.</li> <li>-The nurse documented "Resident receiving P.T. to assist with increasing ambulation. Resident unable to lift arms above head &amp; has limited strength with arms &amp; hands."</li> <li>-The LHPS evaluation did not include frequency of therapy, the resident's response to therapy, or an evaluation of the resident's progress to care.</li> </ul> <p>Interview on 09/02/15 at 3:18 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> <li>-She had lived at the facility one and one-half year.</li> <li>-She was able to ambulate with staff assistance.</li> <li>-She walked slow and took her time walking.</li> <li>-She had physical therapy three times weekly.</li> <li>-The physical therapy was to strengthen her legs in hopes of being independent with ambulation and walking.</li> </ul> <p>Interview on 09/02/15 at 4:48 pm with the Resident Services Director (RSD) revealed:</p> <ul style="list-style-type: none"> <li>-She was a Registered Nurse (RN), and prepared quarterly LHPS evaluations.</li> <li>-It was the facility's protocol that residents applied and removed their own TED hose.</li> <li>-She was aware that due to Resident #4's arthritis the resident was unable to put the TED hose on herself.</li> <li>-She was aware facility staff daily put TED hose on Resident #4 in the AM, and removed the TED</li> </ul>	D 280		

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D 280	<p>Continued From page 25</p> <p>hose at bedtime.</p> <p>-She did not put the TED on the LHPS review, and was unaware they needed to be put on the review because they were supposed to be maintained by the resident.</p> <p>-She had not completed any type of assessment or evaluation on Resident #4 to the TED hose.</p> <p>-The LHPS evaluation did address Resident #4's ambulation and PT, but she was unaware of the type of assessment needed to complete LHPS evaluation.</p> <p>Interview on 09/03/15 at 10:55 am with Resident #4's family member revealed:</p> <p>-Resident #4 moved into the facility in May 2014.</p> <p>-The resident had a disease called lymphedema, and previously had severe swelling and "weeping" of both legs and caused an infection.</p> <p>-The post-treatment for the disease to prevent flare-up was for the resident to wear TED hose.</p> <p>-Resident #4 was ordered TED hose prior to the resident's admission to the facility.</p> <p>-Due to Resident #4's arthritis, previous shoulder replacement, and torn rotator cuff, the resident was unable to put the TED hose on herself.</p> <p>-Since the resident's admission to the facility in May 2014, facility staff put Resident #4's TED hose on in the morning and staff removed the TED hose at night.</p> <p>-She visited Resident #4 two to three days per week and the resident always had the TED hose on.</p> <p>-She observed the TED hose were smooth, did not have wrinkles, creases or lines.</p> <p>C. Review of Resident #1's current FL2 dated 08/26/15 revealed:</p> <p>-Diagnoses included venous leg ulcer, dementia, and chronic kidney disease.</p>	D 280		

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D 280	<p>Continued From page 26</p> <p>Review of the Resident Register for Resident #1 revealed the resident was admitted to facility on 09/04/13.</p> <p>Observation of Resident #1 on 09/02/15 at 8:50 am revealed:</p> <ul style="list-style-type: none"> <li>-Resident was in her room walking around talking to herself and asking questions.</li> <li>-Resident appeared to be confused and would not respond to questions asked.</li> <li>-The resident had on pants down to the ankle.</li> <li>-The resident had on summer shoes that had designed openings on the top of the shoe.</li> <li>-The resident had a stocking on her left leg.</li> <li>-It could not be determined how far up the resident's leg the stocking went up.</li> <li>-The stocking was visible and sheer enough to see the white bandage.</li> <li>-The resident was confused and did not respond when asked what happened to her foot.</li> </ul> <p>Review of Resident #1's record revealed:</p> <ul style="list-style-type: none"> <li>-An order dated 07/24/15.</li> <li>-Resident #1 had an ulcer on her left leg.</li> <li>-The home health nurse was to treat the wound three times weekly.</li> <li>-The physician ordered Tuba-grip compression sleeve (hose/stocking) for the resident's left leg to wear when out of bed to control swelling.</li> </ul> <p>Review of Resident #1's record revealed no LHPS evaluation in the record.</p> <p>Interview on 09/02/15 at 3:46 pm with Resident #1's family member revealed:</p> <ul style="list-style-type: none"> <li>-The resident had a wound on her left leg.</li> <li>-The wound was covered by gauze.</li> <li>-A compression stocking was put on the resident to help with swelling.</li> <li>-Resident #1 was sometimes confused.</li> </ul>	D 280		

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D 280	<p>Continued From page 27</p> <ul style="list-style-type: none"> <li>-Resident #1 sometimes removed the compression stocking on her left leg, especially at bed time.</li> <li>-Facility staff put the stocking back on the resident.</li> </ul> <p>Interview with the RSD on 09/02/15 at 4:48 pm revealed:</p> <ul style="list-style-type: none"> <li>-She was aware that Resident #1 had an order for compression stockings.</li> <li>-She was also aware if the resident removed the stocking, facility staff had to put the stocking back on.</li> <li>-She did LHPS training, but not regarding TED hose or compression stockings.</li> <li>-She was unaware that Resident #1's compression stockings was considered an LHPS task, and needed a quarterly evaluation.</li> </ul> <p>Interview on 09/02/15 at 5:56 pm with the home health nurse revealed:</p> <ul style="list-style-type: none"> <li>-She visited the facility three times weekly to treat the wound on Resident #1's left leg.</li> <li>-When she changed the bandage on the wound she replaced the Tuba-grip.</li> <li>-She was aware that between her visits Resident #1 took the Tuba-grip compression stocking off and facility had to put the stocking back on.</li> <li>-Facility staff were also responsible for washing soiled Tuba-grips.</li> <li>-Initially, she showed the staff person on duty (PCA/MA) how to apply the compression stocking if the resident removed the hose.</li> <li>-She was aware that Resident #1 was confused, but could readily take the compression hose off.</li> <li>-The resident was unaware how to re-apply the hose.</li> </ul> <p>Interview on 09/02/15 at 5:45 pm with two second shift Personal Care Aides/Medication Aide (MA)</p>	D 280		

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D 280	<p>Continued From page 28</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-Most days Resident #1 was confused.</li> <li>-The resident removed the compression stocking on her left leg, mostly at bed time.</li> <li>-Sometimes the resident just took the stocking off.</li> <li>-Staff were responsible for putting the compression stocking back on the resident.</li> </ul> <p>Based on record review, observation and attempt interview on 09/02/15 it was determined that Resident #1 was not interviewable.</p> <p>C. Review of Resident #3's record and current FL-2 dated 7/14/2015 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnosis of: Mitral Valve Disorder, Atrial Fibrillation, Hypertension, Depressive Disorder</li> <li>-Admission to the facility on 7/15/15</li> <li>-Oxygen at 2 liters Continuous.</li> </ul> <p>Review of Resident #3's record revealed:</p> <ul style="list-style-type: none"> <li>-Physician order dated, 7/15/15, Resident can safely self-manage the oxygen.</li> </ul> <p>Review of Resident #3's July, August, and September 2015 Medication Administration Record (MAR) revealed oxygen was not listed on the MAR.</p> <p>Review of Resident #3's LHPS evaluation prepared by the Resident Services Director (RSD) on 7/15/15 revealed:</p> <ul style="list-style-type: none"> <li>-The RSD checked oxygen administration and monitoring as a task.</li> <li>-The RSD documented "Resident on 02@2:NC self manages her 02."</li> <li>-The RSD failed to document the type oxygen delivery and frequency (as needed or continuous).</li> <li>-No documentation of lung assessment or the</li> </ul>	D 280		

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D 280	<p>Continued From page 29</p> <p>resident's response to using oxygen (helpful, not helpful, continues shortness of breath, etc.).</p> <ul style="list-style-type: none"> <li>-The RSD did not document because the resident self-managed the equipment, was the resident compliant or what was the condition or maintenance for the equipment.</li> <li>-There was no documentation regarding the resident's progress related to task and/or any recommendations that was observed based on the assessment and evaluation of the resident.</li> </ul> <p>Review of Resident #3's Assessment and Care Plan dated 7/15/15 and signed by physician on 7/20/15 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #3 used oxygen at 2 liters continuous via nasal cannula.</li> <li>-The resident self-managed her own oxygen.</li> </ul> <p>Observation of Resident #3 on 9/2/15 at 4:45 pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #3 was wearing oxygen with tubing extending from her nasal passage to the portable oxygen tank.</li> <li>-The concentrator was set at 2 liters continuous.</li> <li>-The resident ambulated independently using a walker</li> </ul> <p>Interview with Resident #3 on 9/2/15 at 4:45 pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff helped resident if needed, switched the oxygen portable oxygen tanks.</li> <li>-She was capable of adjusting her oxygen tubing in her nasal passage and around ears without staff assistance.</li> <li>-She was unsure who, or if her oxygen equipment was cleaned.</li> <li>-No one adjusted the flow of the oxygen.</li> <li>-It was set when the machine was delivered.</li> </ul> <p>Interview with a Personal Care Aide/Medication</p>	D 280		

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D 280	<p>Continued From page 30</p> <p>Aide (MA) on 9/2/15 at 5:00 pm revealed: -Resident #3 was on Hospice, the nursed monitored the resident's oxygen. -She learned how to adjust oxygen tubing &amp; exchange oxygen cylinders in nursing aide school -She sometimes assisted Resident #3 with changing portable oxygen cylinders -She assisted Resident #3 with oxygen tubing placement in nasal passages and adjusted over the resident's ears as needed. -She was unsure who maintained and cleaned Resident #3's oxygen components.</p> <p>Interview with the RSD on 09/02/15 at 4:48 pm revealed: -She was aware that Resident #3 was on oxygen. -It was the facility's policy that all residents ordered oxygen self-managed their own oxygen. -She prepared the LHPS evaluation for Resident #3, but did not do a physical assessment or check the condition of the equipment because she was unaware those things needed to be done.</p>	D 280		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant</p>	D912		

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D912	<p>Continued From page 31</p> <p>federal and state laws and rule and regulations related to LHPS competency validation.</p> <p>The findings are:</p> <p>Based on observations, record reviews and interviews, the facility failed to assure 3 of 3 staff (Staff A, B and C) were competency validated by a registered nurse (RN) by return demonstration prior to performing the required tasks for 4 of 4 residents (Residents #1, #2, #3, and #4) with orders for thromboembolism-deterrent (TED) hose, Tuba-grip stocking, and oxygen administration. [Refer to Tag D-0161 10A NCAC 13F .0504(a) Competency Validation LHPS tasks (Type B Violation)].</p>	D912		