

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2016
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NAME OF PROVIDER OR SUPPLIER A TOUCH OF GRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 7028 KITTRIDGE DRIVE FAYETTEVILLE, NC 28314
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 1 - 2, 2016.	C 000		
C 246	<p>10A NCAC 13G .0902(b) Health Care</p> <p>10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure physician notification of blood pressure readings according to physician parameters for 1 of 3 sampled residents (Resident #2).</p> <p>The findings are:</p> <p>Review of Resident #2's current FL-2 dated 06/03/2015 revealed: -Diagnoses included Hypertension and Schizophrenia. -A physician order for blood pressure checks weekly with parameters for systolic readings less than 100 or greater than 180, and diastolic parameters less than 80. -There were no parameters documented for a greater than diastolic reading.</p> <p>Review of the physician orders on Resident #2's current FL-2 dated 06/03/2015 revealed: -A physicians order for Amlodipine Besylate 10mg tablet daily (used to treat high blood pressure). -A physicians order for Metoprolol Succ ER 100mg tablet two times a day (used to treat high blood pressure). -A physicians order for Micardis 80mg tablet daily (used to treat high blood pressure).</p>	C 246		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 246	<p>Continued From page 1</p> <p>Review of blood pressure readings documented for 12/2015 for Resident #2 revealed: -On 12/06/2015 9:25am, diastolic blood pressure reading documented as 70. -On 12/27/2015 10:45am, diastolic blood pressure reading documented as 66. -No documentation the physician was notified regarding the diastolic blood pressure readings less than 80.</p> <p>Review of blood pressure readings documented for 01/2016 for Resident #2 revealed: -On 01/3/2016 7:50am, diastolic blood pressure reading documented as 79. -On 01/31/2016 7:15am, diastolic blood pressure reading documented as 72. -No documentation the physician was notified regarding the diastolic blood pressure readings less than 80.</p> <p>Review of notes documented in Resident #2's record for 01/11/2016 revealed: -Resident #2 complained of dizziness and headache. -Resident #2's blood pressure reading was recorded as (systolic) 156/101 (diastolic) at 10am. -Resident #2's blood pressure reading was recorded as 131/93-diastolic at 11am after resting. -No documentation the physician was notified regarding the blood pressure readings or resident's complaints.</p> <p>Review of notes documented in Resident #2's record for 01/12/2016 revealed: -Resident #2 complained of dizziness, headache, and pain in eyes. -Resident #2's blood pressure reading was</p>	C 246		

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C 246	<p>Continued From page 2</p> <p>134/85-diastolic at 7am. -No documentation the physician was notified regarding the blood pressure reading or resident's complaints.</p> <p>Review of blood pressure readings documented for 02/2016 for Resident #2 revealed: -On 02/07/2016 8:30am, systolic blood pressure reading documented as 98. -On 02/07/2016 8:30am, diastolic blood pressure reading documented as 57. -On 02/14/2016 8:45am, diastolic blood pressure reading documented as 67. -On 02/27/2016 10:44am, diastolic blood pressure reading documented as 75. -No documentation the physician was notified regarding the systolic blood pressure reading documented as less than 100. -No documentation the physician was notified regarding the diastolic blood pressure readings less than 80.</p> <p>Interview with a Medication Aide (MA) on 03/01/2016 at 4:15pm revealed: -The MA was supposed to notify the Administrator when Resident #2's blood pressure readings were high or low or when the resident had swelling in her feet. -The Administrator was responsible to contact the physician once the MA had contacted the Administrator. -The MA had not called the physician about any blood pressure readings for Resident #2.</p> <p>Interview with the Administrator on 03/01/2016 at 4:30pm revealed: -Resident #2's vital sign sheet was reviewed by the physician when the resident went to the doctor's office. -The facility staff thought the physician wanted to</p>	C 246		

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C 246	<p>Continued From page 3</p> <p>be contacted when Resident #2's systolic blood pressure reading was 180 or greater.</p> <ul style="list-style-type: none"> -The physician's office had not been contacted about Resident #2's blood pressure readings. -There was some discrepancy with the blood pressure parameter order that needed clarifying and the Administrator would ensure the order would be clarified. -Resident #2's blood pressure readings were good when Resident #2 had doctor appointments. <p>Telephone interview with the physician's office nurse on 03/01/2016 at 4:35pm revealed:</p> <ul style="list-style-type: none"> -Resident #2's blood pressure had been in good control. -Resident #2 was last seen by the physician on 02/08/2016 and the resident's blood pressure was 133/85. -Resident #2 was seen by the physician in January 2016 and the resident's blood pressure was 126/70 and the physician documented the resident's blood pressure was okay. -The physician would consider the blood pressure elevated if the blood pressure was 180/90. -The physician would consider the blood pressure low if the blood pressure was 90/60. -The physician had not been notified of any of the blood pressure readings at the facility that were outside the parameters. -The physician would have wanted the residents blood pressure readings repeated and to be monitored maybe 1-2 times a day and call back with the readings if the physician had been contacted with high or low blood pressure readings. <p>Interview with Resident #2 on 03/01/2016 revealed the resident had no complaints.</p>	C 246		

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C935	Continued From page 4	C935		
C935	<p>G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency</p> <p>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.</p> <p>(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:</p> <p>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ul style="list-style-type: none"> a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <ul style="list-style-type: none"> a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: <ul style="list-style-type: none"> 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 	C935		

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C935	<p>Continued From page 5</p> <p>exists.</p> <p>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 1 staff (Staff A) who began performing medication aide duties after October 1, 2013 met the requirements to administer medications.</p> <p>The findings are:</p> <p>Review of Staff A's personnel file revealed: -Staff A was hired to work for the corporation on 12/31/2013. -Staff A began working at the facility as a Supervisor/Personal Care Aide/Medication Aide on 08/01/2015. -Staff A completed Medication Clinical Skills Checklists on 01/10/2014, 09/04/2014, 01/06/2015, 10/13/2015, and 01/05/2016. -Staff A completed the 5 hour medication training on 09/04/2014. -No documentation for medication aide employment verification. -No documentation for the 10 hour medication training being completed. -No documentation for the 15 hour medication training being completed.</p> <p>Observation of Staff A on 03/01/2016 from 12:20pm to 12:30pm revealed: -Staff A administered medication in a cup to Resident #3 in the dining room. -Staff A documented the administration of the</p>	C935		

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C935	<p>Continued From page 6</p> <p>medication after administering the medication.</p> <p>Interview with Staff A on 03/01/2016 at 9:30am revealed:</p> <ul style="list-style-type: none"> -Staff A worked at the facility every day. -Staff A slept at the facility during the night. -Staff A's responsibilities included medication administration to the residents living in the facility. -There was one resident at the facility who required the staff to perform finger stick blood sugar checks but the resident did not require insulin administration. <p>Review of the February 2016 Medication Administrations Records for Resident #1 revealed:</p> <ul style="list-style-type: none"> -Staff A documented finger stick blood sugar checks on Mondays, Wednesdays, and Fridays. -Staff A documented administration of oral medications daily at 8:00am. <p>Review of the February 2016 Medication Administrations Records for Resident #2 revealed:</p> <ul style="list-style-type: none"> -Staff A documented administration of oral medications daily at 8:00am. -Staff A documented administration of nasal spray medication as needed by the resident. <p>Interview with the Administrator on 03/01/2016 at 5:30pm revealed:</p> <ul style="list-style-type: none"> -The Administrator thought the Medication Aide had to complete the 5 hour "or" 10 hour medication aide training. -Staff A had additional training on medication administration with the facility nurse but the training was not a state approved training. -The Administrator had not done any medication aide employment verification for Staff A. -The Administrator had talked with Staff A prior employer before Staff A was hired in the home 	C935		

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C935	Continued From page 7 but the conversation was only to confirm Staff A's ability to pass meds but did not verify Staff A had worked as a medication aide in the prior 24 months.	C935		