STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL093012	A. BUILDING: _____ B. WING _____	R 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIVOTAL CARE	303 W FRANKLIN STREET WARRENTON, NC 27589

(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
{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey with an onsite visit on February 2, 2021 and a desk review survey on February 3, 2021 to February 5, 2021 and a telephone exit on February 5, 2021.	{C 000}		
{C 074}	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the walls and carpeting in the common hallway, an air vent on the corner of the living room wall, the windows, windowsills, ceiling fans, ceilings and flooring in three of four resident bedrooms and windows and windowsills in the dining room, and the door to a resident bedroom that would not open and close properly, were kept clean and in good repair. The findings are: Observation of the dining room on 02/02/21 at 10:00am revealed: -One of the windows did not close and had a stick of wood at the top to push it closed. -There was a 1-inch gap on one side where the window was open and did not close.	{C 074}		

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{C 074}	Continued From page 1 Observation of the common hallway on 02/02/21 at 11:19am revealed: -There was a common hallway that turned a corner and lead from the living room to four residents' bedrooms and a resident bathroom. -There was carpeting in the common hallway that was dirty and stained with black spots. -There was a door frame that lead to a resident's bedroom that had a thick layer of dust on it. -There was corner of the hall that had chips and sections of the plaster missing, and was also stained with dried and discolored splatters and drips from a liquid. -There was an air vent at the corner of the common hallway and the living room that had a thick layer of dust on the vent cover. -There were dried and discolored drips and splatters from a liquid on the walls in the common hallway. -There was a thick layer of dust on a set of emergency lights above a door to one of the resident bedrooms. Observation of a resident room on 02/02/21 at 1:02pm revealed: -There were two residents who resided in the bedroom. -The door to the bedroom stuck in the frame when pushed closed or pulled open from inside the bedroom. -The bottom of the door dragged on the carpet and had to be pulled open or closed with force. -The top hinge on the door moved out of place when the door was opened or closed, and the door had to be lifted slightly to close it. -The ceiling in the residents' bedroom had clumps of dust stuck to it.	{C 074}		

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{C 074}	Continued From page 2 Interview with a resident who resided in the first bedroom on 02/02/21 at 1:15pm revealed: -The door to her room had always dragged on the floor when it was opened or closed. -She just pulled or pushed on it to get it to open or closed; it had gotten worse since she had been living there. -She could open the door from the hallway because she pushed it open, but she had to pull "hard" to open it from the inside. -The door did not close all the way. -She never complained about the door to anyone because it had always been that way and she guessed they knew. Interview with a second resident who resided in the first bedroom on 02/02/21 at 5:08pm revealed: -The door had been "that way" since she had lived at the facility. -The door was hard to open and close. -She did not know if the staff or the Administrator knew about the door; she had never complained about the door. Telephone interview with a medication aide (MA) on 02/04/21 at 8:00am revealed: -He reported any broken items to the Administrator, and she would make sure everything got fixed. -He was aware of the damaged door to a resident room; "it sticks is all". -He thought the Administrator knew about the damaged door, but he had not told her. Observation of a second resident bedroom on 02/02/21 at 1:28pm revealed: -There was one resident who resided in the bedroom. -There was a ceiling fan that had a thick layer of	{C 074}		

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{C 074}	Continued From page 3	{C 074}		

dust and there were clumps of dust on the ceiling.
-There were cobwebs on the ceiling fan; the cobwebs had a thick layer of dust on them .
-There was a black substance that lined the edges of the glass on the inside of the window and on the windowsill.
-There was chipped and missing plaster and a black substance in the corners of the windowsill.
-The window was propped open with a small block and the screen was missing.
-There was a black residue on the floor in the corners and along the baseboard in the bedroom.

Interview with the resident who resided in the bedroom on 02/02/21 at 1:30pm revealed:
-He cleaned, swept and mopped his own bedroom.
-The screen fell out of the window a long time ago; he had always propped his window open.
-He did not complain about the window, because he was okay with it like it was.

Observation of a third resident bedroom on 02/02/21 at 1:30pm revealed:
-There was one resident that resided in the bedroom.
-The carpet was frayed and torn near the wall.

Interview with the resident who resided in the third bedroom on 02/02/21 at 1:38pm revealed the carpet had always been frayed and she never told anyone about it.

Interview with a medication aide (MA) on 02/02/21 at 2:31pm revealed:
-She had not seen the dust on the ceiling fans and ceilings in the resident bedrooms.
-She had not seen the dried splatters and drips on the walls.
-She did not know if a cleaning provider had

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{C 074}	Continued From page 4	{C 074}		

come into the facility to do a deep cleaning.
-She had never cleaned the walls and she had never dusted the ceiling fans because the residents cleaned their own bedrooms.

Telephone interview with a MA on 02/04/21 at 7:47am revealed he did not clean walls, vents, or ceiling fans because the facility had a crew that did that.

Telephone interview with a second MA on 02/04/21 at 11:39am revealed:
-She dusted the common areas and vacuumed daily; she dusted the air vent in the living room once a week.
-She dusted the ceiling fans in the common areas but not in the resident rooms because they clean their own bedrooms.

Telephone interview with the Administrator on 02/04/21 at 9:17am revealed:
-She had paid a cleaning provider to come in and clean the carpets and the walls in November 2020; she did not inspect the walls or carpet after they were complete.
-Staff should have been dusting daily including the ceiling fans and the walls.
-She was aware of the black substance on the windows and the windows needed to be repaired; they had been that way for months.
-The landlord was going to replace them, but she did not know when.
-She did a walk around when she was at the facility and did an inspection; she would tell the staff to clean while she was there if she noticed anything that needed to be done.
-She was last there on 02/02/21 but was only there for a few minutes to drop off staff records; she had not noticed the issues.
-She was shocked to know there was a missing

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{C 074}	Continued From page 5 toilet seat on the private bathroom shared by the residents that resided in the bedroom. -Neither resident was ordered or needed a bedside commode. -She had last seen the bathroom about one month ago. -She was not aware of the door to the bedroom was sticking and was difficult to open and close. -She had opened and closed the door very quickly when she was at the facility on 02/02/21 because she was appalled at the condition and disarray of the bedroom. -The landlord had replaced all the ceiling fans in November 2020. -She visited the facility one to two times a week and did a walk around and inspected everything. -The staff were supposed to call her and let her know if something needed to be repaired. Telephone interview with the facility's landlord on 02/04/21 at 3:01pm revealed: -She had not been inside the facility since December. -The lease agreement she had with the facility was anything over one-thousand dollars she would repair or replace. -She was not aware the door in a resident's room was sticking; no one had reported it to her. -The Administrator could have fixed the door or let her know, and she would have had the door repaired. Attempted telephone interview the cleaning provider on 02/03/21 at 1:30pm was unsuccessful.	{C 074}		
{C 076}	10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings	{C 076}		

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{C 076}	Continued From page 6 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the chairs in the dining room, and a dresser in a resident bedroom, and lamps in two residents bedrooms were kept clean and in good repair. Observation of the dining room on 02/02/21 at 1:20pm revealed: -There were two high backed upholstered chairs at the dining room table, the tops and seats of both chairs were discolored and had stains and dark spots on them. -There was a vinyl arm chair that had a tear in the vinyl on one of the arms and there was a four-inch and three-inch tear in the seat. Observation of one of the resident's bedroom on 02/02/21 at 1:30pm revealed: -There was a knob missing off one of the dresser drawers. -There was a layer of dust and dried splatters and drips from liquids on the mirror attached to the dresser. -There was a lamp with a working light bulb sitting on the dresser but no lampshade. Interview with the resident that resided in the bedroom on 02/02/21 at 1:30pm revealed: -He did not mind the missing knob on the dresser. -The lamp had always been without a lampshade and he was "okay" without a lampshade on his	{C 076}		

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{C 076}	Continued From page 7 lamp. Observation of a second resident bedroom on 02/02/21 at 1:38pm revealed there was a single lamp on the dresser in the bedroom; the lamp was on and the lamp shade was missing. Interview with the resident that resided in the third bedroom on 02/02/21 at 1:38pm revealed she did not know how long the lamp had been without a lampshade, but she did not mind that it did not have a shade and never reported it to anyone. Telephone interview with the Administrator on 02/04/21 at 9:03am revealed: -She had not addressed the dressers yet because they came with the facility when she rented the building. -She would have to work with the landlord to replace the furnishings. -She was aware of the condition of the high backed upholstered chairs in the dining room; they were "filthy". -She had not seen the vinyl chair, but she knew it was old and it would not surprise her if is had tears in it; the chair was "worn out". -She had been aware of the issues with the furniture for months; she had given the landlord a list of items, but the landlord was not willing to work with her. -She thought all the lamps in the residents' bedrooms had lamp shades. -She could not remember the last time she had purchased lampshades for the residents; "I just do not know what they do with them". Telephone interview with the facility's landlord on 02/04/21 at 3:01pm revealed: -She had not been inside the facility since December 2020.	{C 076}		

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{C 076}	Continued From page 8 -The lease agreement she had with the facility was anything over one-thousand dollars she would repair or replace. -There were dining room chairs in the facility when it was leased, but she did not know if the dining room chairs that were currently there were the original chairs or not. -If the dining room chairs needed to be replaced, she would have expected the Administrator to have handled it. -The Administrator was responsible for replacing furniture when there was a need for it to be replaced or repaired.	{C 076}		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that one of four resident bedrooms and two of two resident bathrooms were maintained in an uncluttered, clean and orderly manner. Observation of a resident bedroom on 02/02/21 at 12:38am revealed: -There were two residents that resided in the bedroom.	C 078		

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C 078	Continued From page 9 -There was a reclining chair in the middle of the room that had clothes laying on the seat and arms of the chair. -There were four bins and tubs for clothes scattered around the room that were overflowing with clothes. -There was a dresser with clothes stacked on top of it. -There was a walker in the middle of the room with clothes hanging on it. -There were four pairs of shoes on the floor in the middle of the room. -There were miscellaneous items scattered about the floor of the room including a stuffed animal and an empty black trash bag. Interview with a resident who resided in the bedroom on 02/02/21 at 1:00pm revealed she was responsible for cleaning her own room and putting her own clothes away; the staff did not clean her room. Interview with the second resident who resided in the bedroom on 02/02/21 at 5:08pm revealed: -She cleaned her own room when it needed to be done; staff did not clean her room. -She vacuumed her own floor, but she did not dust her room. -She washed her own clothes and put them away. -She never complained. Observation of a resident bathroom on 02/02/21 at 12:45pm revealed: -There was a private bathroom that was only accessible through a resident bedroom. -The bathroom was only used by the two residents who resided in the bedroom. -The toilet had yellow stains around the hinges where the seat would have been attached; the toilet seat and lid were missing.	C 078		

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C 078	Continued From page 10 -There were brown smears down the front of the toilet. -The vanity where the sink was had brown stains on it and the laminate was separating from the side. -The floor had debris on it and there were stains around the base of the toilet. -There was a padded ottoman next to the vanity that was rusted and covered in a white residue. Interview with a resident who used the private bathroom on 02/02/21 at 1:00pm revealed: -She and her roommate were the only residents who used the private bathroom. -She cleaned her own bathroom; she cleaned the toilet, the sink, the floor and the bathtub. Interview with the second resident who used the private bathroom on 02/02/21 at 5:08pm revealed: -She cleaned her own bathroom. -She got the cleaning product from the staff and used it herself. -She never complained. Telephone interview with the Administrator on 02/03/21 at 1:15pm revealed: -She had seen the room that was shared by two residents on 02/02/21 when she was at the facility. -She was "shocked" at the condition of the room; it was the worse she had ever seen it. -The room was a disarray of clothes on the dresser, on the reclining chair and in tubs and baskets on the floor. -There was enough room in the closet and the dresser to hold all the residents' belongings. -The residents in the room did not need a walker; it belonged to another resident and she did not know why it was in that room.	C 078		

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-The reclining chair was not supposed to be in the middle of the room.
-The condition of the room was unacceptable and did not happen in just one day.
-The staff should have kept up better than that.
-The staff were to clean the bathrooms once a day and wipe them down several times a day; including the sink, toilet and the tub.
-She did not see the bathrooms when she was at the facility on 02/02/21 because she was not there that long.

Observation of second resident bathroom on 02/02/21 at 2:00pm revealed:
-The bathroom was on the common hallway.
-There was debris, a pair of used socks, and bits of toilet paper on the floor in the bathroom.
-The floor around and the wall behind the base of the toilet had yellowish brown residue buildup and stain on them.
-The toilet had yellow and brown residue and debris on it around the hinges for the seat and the base.
-There was something that was smeared on the wall nest to the toilet paper dispenser; the smear was brown and black in color.
-The vanity and the sink both had debris and a gray residue.

Interview with a MA on 02/02/21 at 2:24pm revealed:
-The residents were responsible for cleaning their own bedrooms and the bathroom if they had one in their room.
-Staff were only responsible for cleaning the common areas including the main hallway bathroom, the living room and the dining room.
-The residents had to dust, sweep and mop or vacuum their own rooms.
-The residents had to clean the bathtub in the

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C 078	Continued From page 12	C 078		

main hallway after they used it.
-The resident would get the spray cleaner from the staff and wipe the bathtub down.
-She cleaned everything else in the bathroom including the sink, toilet and floor every day.
-She wiped everything in the bathroom down four times a day.
-She had not had a chance to clean the bathroom that day.

Interview with the second MA on 02/02/21 at 5:43pm revealed:
-She only worked overnight; she cleaned the common areas and the kitchen.
-She cleaned the second bathroom located in the common hallway; she would clean the bathtub if the residents did not do it after they took a shower.
-The residents cleaned their own rooms, but the staff would help if the resident needed it.
-The residents cleaned the floors in their rooms, dusted, folded and put away their own clothes.
-She would clean the residents' private bathroom that was in the residents' bedroom if it needed it; she had cleaned it on 01/28/21.

Telephone interview with a third MA on 02/04/21 at 7:47am revealed:
-He cleaned the second bathroom on the common hallway; he cleaned the toilet, sink and shower.
-He did not clean the private bathroom in located in the residents' bedroom.
-He worked mostly at night, so he did not clean the resident bedrooms or do laundry.
-The residents' cleaned their own bedrooms and put away their own laundry; he "liked for them to do for themselves".
-He would help a resident if they needed it.

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C 078	Continued From page 13	C 078		

Telephone interview with the Administrator on 02/04//21 at 9:17am revealed:
-The residents were not supposed to clean anything or do their laundry.
-The staff were responsible for cleaning the residents' bedrooms and bathrooms daily, including vacuuming the floors.
-The staff were responsible for washing the residents' clothes and folding and putting them away.
-She visited the facility one to two times a week and did a walk around and inspected everything.

Telephone interview with the facility's landlord on 02/04/21 at 3:01pm revealed:
-She had not been inside the facility since December.
-The lease agreement she had with the facility was anything over one-thousand dollars she would repair or replace.
-She was not aware the commode in a resident's room did not have a commode seat, but she would have expected the Administrator to have handled obtaining a commode seat if it was needed.
-She was not aware the door in a resident's room was sticking; no one had reported it to her.
-The Administrator could have fixed the door or let her know, and she would have had the door repaired.
-She was not aware the ceiling heater in the hallway bathroom was loose and was hanging by the wires on one side.
-She had an electrician in the facility "a few months ago" and he could have repaired the heater light then if it had been a problem.
-She was aware there had been "new" leaks in the facility because the shingles had been removed and were going to be replaced but due to the rainy weather, the roof was not finished and

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C 078	Continued From page 14 had been covered with a tarp. -As soon as the roof is repaired, she will have a contractor repair water damage on the inside ceilings and paint.	C 078		
{C 102}	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all electrical equipment and plumbing in bathroom was maintained in a safe operating condition related to the light fixture in two resident bedrooms not working, a ceiling heater that was not properly supported in the ceiling, and the toilet seat and lid missing from the toilet in a resident bathroom. The findings are: Observation of the residents' common bathroom on common hallway on 02/02/21 at 11:18am revealed: -There was a small round space heater on the ceiling that had a wire cover on it; the heater was on and working because the heating element was a bright red. -The base of the heater was not secure and had partially separated on one side and was hanging	{C 102}		

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{C 102}	Continued From page 15 from the ceiling. Observation of a resident room on 02/02/21 at 1:02pm revealed: -There were two residents who resided in the bedroom. -There was a ceiling fan with a light that did not have a light bulb and the socket was exposed. -There was a private bathroom that was only accessible from the residents' bedroom. -There was a bedside commode placed over the toilet in lieu of a lid. -The toilet seat and lid were missing and there were only hinges where the lid was once attached. Interview with a resident who resided in the first bedroom on 02/02/21 at 1:15pm revealed: -There was a bedside commode seat that was placed over the toilet and the toilet did not have a toilet seat and lid. -She would rather have a toilet seat and lid rather than the bedside commode. -She had told the staff about the request to have a regular toilet seat instead of the bedside commode, but she was told that it had always been like that. -She and her roommate did not need the bedside commode to use the toilet. -The light bulb in the ceiling fan burned out a couple of weeks ago; the staff knew because they took the light bulb out. Telephone interview with a medication aide (MA) on 02/04/21 at 11:50am revealed: -She was not aware of the missing toilet seat and lid; the residents had not complained to her about it. -There had always been a bedside commode over the toilet, so she thought one of the	{C 102}		

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{C 102}	Continued From page 16 residents needed it. Observation of a second resident bedroom at the end of the common hallway on 02/02/21 at 1:28pm revealed the ceiling fan did not have a light bulb in it and the socket was exposed. Interview with the resident who resided in the second bedroom on 02/02/21 at 1:28pm revealed: -He did not have a roommate. -He was okay without a light in the ceiling fan. Interview with a medication aide (MA) on 02/02/21 at 3:50pm revealed: -The light bulb in the residents' rooms had just burned out a day ago. -She told the Administrator when the light burned out and the Administrator would bring a bulb that fit the light on the ceiling fan. Telephone interview with a second MA on 02/04/21 at 8:00am revealed he had not noticed any missing light bulbs. Telephone interview with the Administrator on 02/04/21 at 9:23am revealed: -She was shocked to know there was a missing toilet seat on the private bathroom shared by the residents that resided in the room. -Neither resident was ordered or needed a bedside commode; she had last seen the bathroom about one month ago. -She was not aware of the door to the bedroom was sticking and was difficult to open and close. -She had opened and closed the door very quickly when she was at the facility on 02/02/21 because she was appalled at the condition and disarray of the bedroom. -The landlord had replaced all the ceiling fans in	{C 102}		

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{C 102}	Continued From page 17 November 2021. -She thought the heater on the ceiling of the main bathroom had been removed in November 2020; an electrician had removed all the baseboard heaters and he should have removed that one as well. -She visited the facility one to two times a week and did a walk around and inspected everything. -The staff were supposed to call her and let her know if something needed to be repaired. Telephone interview with the facility's landlord on 02/04/21 at 3:01pm revealed: -She had not been inside the facility since December 2020. -She was not aware the ceiling heater in the hallway bathroom was loose and was hanging by the wires on one side. -She had an electrician in the facility "a few months ago" and he could have repaired the heater light then if it had been a problem.	{C 102}		
{C 140}	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis	{C 140}		

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{C 140}	Continued From page 18	{C 140}		

disease that poses a direct threat to the health or safety of others.

This Rule is not met as evidenced by:
FOLLOW UP TO A TYPE B VIOLATION

The Type B Violation is abated. Non-compliance continues.

Based on record reviews and interviews, the facility failed to ensure 2 of 4 sampled staff (A and D) was tested for tuberculosis (TB) according to control measures adopted by the Commission for Health Services.

The findings are:

1. Review of Staff A's Supervisor-in-Charge (SIC), personnel record revealed:
-Staff A was hired on 09/23/20.
-There was no documentation Staff A was tested for TB.

Interview with Staff A on 02/02/21 at 3:50pm revealed:
-She had been working at the facility for almost a year.
-She worked as a medication aide (MA).
-She had a TB skin test done at the local health department, but she did not know if the Administrator had gotten the results from the office.
-The TB skin test was done in December 2020 and it was negative.
-She did not have a copy of the TB test results and she had not given the Administrator a copy.

Telephone interview with the Administrator on 02/04/21 at 8:29am revealed:
-She did not know why Staff A's results were not

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{C 140}	Continued From page 19 in her record. -The results should have been in Staff A's record; she knew Staff A had a negative result. -She had sent Staff A to the local health department to get her TB skin test done in December 2020. 2. Review of the facility's personnel records revealed Staff D did not have a personnel record. Telephone interview with Staff D on 02/04/21 at 11:39am revealed: -She had been working as a medication aide (MA) at the facility since September 2020 or October of 2020. -She had a TB test done in August 2020 and it was negative. -She had not given the results to the Administrator; she had difficulty getting them from the medical provider. Telephone interview with the Administrator on 02/04/21 at 8:25am revealed: -Staff D should have had a negative TB test result in her folder, but she could not find Staff D's personel record. -She was responsible for all staff records and ensuring everything was complete. -Staff D worked as a MA and worked weekends at the facility. -Staff D "sporadically" so it was difficult to get information from her. -She was aware of the rule requiring staff to have a record of a negative TB test.	{C 140}		
{C 145}	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications	{C 145}		

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{C 145}	Continued From page 20 (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 4 sampled staff (Staff D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of the facility's personnel records revealed Staff D did not have a personnel record. Telephone interview with Staff D on 02/04/21 at 11:39am revealed: -She had been working as a medication aide (MA) at the facility since September 2020 or October of 2020. -She did not know if the Administrator had done a HCPR check for findings. Telephone interview with the Administrator on 02/04/21 at 8:25am revealed: -Staff D should have had a partial record at the facility, but she could not find Staff D's personel record. -She had checked the HCPR for findings for Staff D in December 2020; the document should have been in her record. -Staff D did not have any findings when she checked the HCPR. -She was responsible for all staff records and ensuring everything was complete. -Staff D worked as a MA and worked weekends	{C 145}		

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{C 145}	Continued From page 21 at the facility. -Staff D "sporadically" so it was difficult to get information from her. -She was aware of the rule requiring staff to have a record of the HCPR prior to hire to ensure there were no substantial findings.	{C 145}		
{C 147}	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 4 sampled staff, (Staff D), had a criminal background check completed upon hire. The findings are: Review of the facility's personnel records revealed Staff D did not have a personnel record. Telephone interview with Staff D on 02/04/21 at 11:39am revealed: -She had been working as a medication aide (MA) at the facility since September 2020 or October of 2020. -She had not had a criminal background check done for this facility. Telephone interview with the Administrator on 02/04/21 at 8:25am revealed: -Staff D should have had a partial record at the	{C 147}		

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{C 147}	Continued From page 22 facility, but she could not find Staff D's personel record. -She had not had a chance to get Staff D's drivers license information to do the criminal background check. -She had not done a criminal background check for Staff D because Staff D worked sporadically and was hard to get information from. -She was going on "faith" that everything was done for Staff D for another facility she worked at. -She was responsible for all staff records and ensuring everything was complete. -Staff D worked as a MA and worked weekends at the facility. -She was aware of the rule requiring staff to have a record of a criminal background check completed prior to hire.	{C 147}		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure 1 of 5 sampled resident (#5) was supervised in accordance with their assessed needs and current symptoms related to smoking inside the facility. The findings are: Observation on 02/02/21 at 1:28pm revealed:	C 243		

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C 243	Continued From page 23 -There was a strong smell of smoke or something burning in the hallway that lead to three of the residents' rooms. -There was a room with the door open and a resident sitting in a rocking chair doing a crossword puzzle. -There was a second room with a door closed and no one was in the room. -The odor was strongest at a third room with the door closed; Resident #5 was sitting in the room alone. -The window in Resident #5's room was open, and the screen was missing. -There were ashes on the outside of the window seal. -The room had the scent of smoke or something burning. Observation of the outside of the facility on 02/02/21 at 6:00pm revealed there were multiple cigarette butts on the ground under Resident #5's window. Review of Resident #5's FL-2 dated 02/09/19 revealed diagnoses included schizophrenia, diabetes mellitus, hypertension, nicotine dependency, depression, glaucoma, Bell's palsy, and human papillomavirus. Review of Resident #5's Care Plan dated 02/19/20 revealed there was no documentation of a smoking assessment or supervision needs related to smoking. Review of a document in Resident #5's record titled Warning and Breaking the [House] rules protocol dated 03/01/17 revealed: -Resident #5 did not sign the document. -The first offense for breaking house rules was a verbal warning, the second offence was a written	C 243		

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warning and upon the third offence the resident would be given a 30-day discharge notice.

Review of the Tobacco use policy in Resident #5's record revealed it was dated 03/01/17:
-Resident #5 did not sign the document.
-Rule number one was the resident must use the designated smoking are located outside when smoking.
-Rule number two was there was no smoking inside facility.
-The staff would report to the Administrator whenever there a rule was broken.
-The Administrator would take action when the residents violated the rules.
-The first action take would be a verbal warning; the second offence was a written warning and upon the third offence the resident would be given a 30-day discharge notice.

Review of a Smokers Agreement dated 01/01/18 revealed:
-The document was signed by Resident #5.
-There would be a two dollar fine for smoking inside the facility.
-There was a statement that read it was against the law to smoke in the facility.

Review of the shift change communication log for the month of January 2021 revealed:
-On 01/05/21 there was a note Resident #5 was still smoking in his room.
-The staff could smell the smoke in the hallway.
-On 01/15/21 there was a note Resident #5 was still smoking in his room.

Interview with Resident #5 on 02/02/21 at 1:30pm revealed:
-He was not smoking in his room.
-He had smoked in his room a "long time ago",

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but he did not do it anymore because he would get written up for breaking the rules.

Telephone interview with a resident that resided across the hall on 02/03/21 at 2:06pm revealed:
-She had not noticed an odor in the hallway, and she had not smelled cigarette smoke.
-She had never heard of anyone smoking inside the facility.
-She kept her door closed most of the time for privacy and not because of any odors.

Telephone interview with Resident #5's friend on 02/04/21 at 3:01pm revealed:
-She had been Resident #5's "care provider" for over 17 years.
-If there was anything going on with Resident #5, she expected to be notified.
-She had not been notified of Resident #5 smoking inside "lately."
-She had been notified "about 6-7 months ago" Resident #5 had been smoking in his room and she had talked to Resident #5 about smoking inside at that time.

Telephone interview a medication aide (MA) on 02/04/21 at 7:47am revealed:
-The residents were not allowed to smoke in the facility; residents were not allowed to have cigarettes, matches or lighters.
-The staff passed out the cigarettes and lighters to the residents when it was time to smoke.
-There were scheduled smoking times and a designated smoking area outside.
-He was not aware of any residents smoking in their rooms and he had never smelled smoke in the facility.

Interview with a second MA on 02/04/21 at 11:14am revealed:

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C 243	Continued From page 26 -She had smelled the scent of cigarette smoke on Resident #5. -It was hard to tell if the scent was in Resident #5's clothes or skin. -She had seen Resident #5's room look "smokey" and there was a strong scent of smoke. -She had smelled the scent of cigarette smoke coming from Resident #5's room. -She thought she had last smelled the scent of cigarette smoke in Resident #5's room about two weeks ago. -When she smelled cigarette smoke, she notified the Administrator and documented the information in the communication log. -The Administrator had talked to Resident #5 about smoking in his room, but he continued to smoke in his room. Telephone interview with a third MA on 02/05/21 at 12:00pm revealed: -She had smelled smoke on Resident #5 and in the hallway. -She did not go into Resident #5's room because he was always in it. -Resident #5 would tell her it was not him smoking in his room when she asked him. -She had told the Administrator about Resident #5 smoking in his room but had not documented it and thought the last time was before January 2021. Telephone interview with a forth MA on 02/05/21 at 12:26pm revealed: -She smelled smoke or something burning in the hallway on 02/02/21; it was not the first time she had smelled the odor. -She was pretty sure it was Resident #5. -When she smelled it before she had asked Resident #5 if it was him; he told her it was not him.	C 243		

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C 243	Continued From page 27 -She had not seen Resident #5 smoking in his room, but she could smell it on him and in his room. -She wrote in the communication log each time she smelled smoke; she did not know if the Administrator knew or looked at the communication log. Telephone interview with the Administrator on 02/04/21 at 8:37am revealed: -The residents were not allowed to smoke anywhere inside of the facility. -There were scheduled times for smoking and a designated area outside to smoke. -The staff went outside and monitored the residents while they smoked. -The residents were not allowed to have cigarettes or lighters; the staff gave them out at smoke breaks. -Resident #5 had smoked cigarettes in his room. -Resident #5 had a nonfamily member that would give him cigarettes when she came to visit him; she had been told not to give them to the resident but to give them to the staff to hold. -The Administrator smelled smoke or something burning when she was in the facility on 02/02/21 but she was not sure where the smell came from. -She did ask Resident #5 if he had been smoking in his room and he told her "no". -She asked the MA on duty if they had smelled smoke or something burning and the MA had also smelled it but did not know where the smell was coming from. - "If you [staff] could smell smoke or something burning in the facility then you [staff] are not monitoring." -Resident #5 had already been given two notices for breaking the facility rules and she would give him a third notice; after three notices she would begin the discharge process.	C 243		

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C 243	Continued From page 28 -The notices were given to Resident #5 for breaking the no smoking in the facility rule; he had been caught smoking in his room multiple times in the last year. -She tried to control the smoking at the facility with the scheduled break times; Resident #5 would get mad at her for the restrictions. -She told the staff to call her when they smelled cigarette smoke in the facility; it was hard to prove who was smoking. -She was concerned Resident #5 could catch the facility on fire and burn it down. _____ The facility failed to provide supervision in accordance to the facility's smoking policy for Resident #5 who did not follow the facility's smoking policy and was known to smoke in his bedroom, The failure of the facility was detrimental to the health and safety to the residents and constitutes a Type B Violation. _____ The facility was provided a plan of protection in accordance with G.S. 131D-34 on 02/24/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION WILL NOT EXCEED MARCH 22, 2021.	C 243		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by:	C 311		

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C 311	Continued From page 29 Based on observations, and interviews the facility failed to ensure each resident was treated with respect, consideration, dignity, and right to privacy related to residents having to perform cleaning task including washing, folding and putting away of their own laundry, cleaning of floors in their own bedrooms and two residents who cleaned the bathroom in their shared bedroom. The findings are: Interview with a resident on 02/02/21 at 1:00pm revealed: -She had to wash her own clothes and sheets; she also folded and put away her own clothes. -She cleaned her own bathroom; she cleaned the toilet, the sink, the floor and the bathtub. -The staff told her to clean the bathroom and do her laundry; she guessed she had to do it to live there. Interview with a second resident on 02/02/21 at 1:30pm revealed: -He washed his clothes and sheets today and would be able to put the sheets on the bed after they dried. -He sometimes swept and mopped his own floor because it needed to be done. Interview with a third resident on 02/02/21 at 1:38pm revealed: -She put her own clothes into the washer and the staff washed and dried them for her; each resident had a scheduled day to wash their clothes. -She always folded her own clothes and she put them away herself; the staff told her to do it herself and she did not mind. -Sometimes she cleaned the floor in her room	C 311		

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C 311	Continued From page 30	C 311		

and sometimes the staff did it.

Interview with a forth resident on 02/02/21 at 5:08pm revealed:
-She cleaned her own bathroom.
-She got the cleaning product from the staff and used it herself.
-She cleaned her own room when it needed to be done; staff did not clean her room.
-She vacuumed her own floor, but she did not dust her room.
-She washed her own clothes and sheets.

Interview with a medication aide (MA) on 02/02/21 at 2:24pm revealed:
-The residents were responsible for cleaning their own rooms and the bathroom if they had one in their room.
-Staff were only responsible for cleaning the common areas including the main hallway bathroom, the living room and the dining room.
-The residents had to dust, sweep and mop or vacuum their own rooms.
-The residents had to clean the bathtub in the main hallway after they used it.
-The resident would get the spray cleaner from the staff and wipe the bathtub down.

Interview with the second MA on 02/02/21 at 5:43pm revealed:
-She only worked overnight; she cleaned the common areas and the kitchen.
-She cleaned the main hallway bathroom; she would clean the bathtub if the residents did not do it after they took a shower.
-The residents cleaned their own rooms, but the staff would help if the resident needed it.
-The residents cleaned the floors in their rooms, dusted, folded and put away their own clothes.
-The residents were free to refuse to clean their

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C 311	Continued From page 31 rooms. -She would clean the resident bathroom that was in the residents' room if it needed it; she had cleaned it on 01/28/21. Telephone interview with a third MA on 02/04/21 at 7:47am revealed: -He cleaned the main bathroom, but he did not clean the bathroom in the residents' rooms. -He made the residents' beds in the morning, but he did not do the laundry because he worked mostly at night. -The residents' cleaned their own rooms and put away their own laundry; he "liked for them to do for themselves". -He would help a resident if they needed it. Telephone interview with the Administrator on 02/04//21 at 9:17am revealed: -The residents were not supposed to clean anything or do their laundry. -The MAs were responsible for cleaning the residents' rooms daily, including vacuuming the floors. -The MAs were responsible for washing the residents' clothes and folding and putting them away. -There was a schedule for staff to follow to wash the residents' clothes; the schedule was not meant for the residents to wash their own clothes. -She did not want the residents to use the clothes washer or dryer. -She did not know why the residents thought they had to do the cleaning; she was unsure if the MAs told the residents to or because the MAs were not doing it.	C 311		
{C 330}	10A NCAC 13G .1004(a) Medication Administration	{C 330}		

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{C 330}	Continued From page 32 10A NCAC 13G .1004 Medication Administration (a) A family 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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered to 1 of 3 sampled residents (#1) including a Nonsteroidal anti-inflammatory drug used to treat mild pain and a narcotic used to treat moderate to severe pain. The findings are: Review of Resident #1's current FL-2 dated 12/30/20 revealed diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis, hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion. Review of Resident #1's physician's order dated 12/11/20 revealed an order for Ibuprofen 800mg (a nonsteroidal anti-inflammatory drug used to treat mild pain) three times daily as needed for pain. Review of Resident #1's physician's order dated	{C 330}		

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{C 330}	Continued From page 33 01/29/21 revealed an order to stop Ibuprofen and begin Tramadol 50mg (a narcotic used to treat moderate to severe pain) one tablet twice a day as needed. Review of Resident #1's physician's summary dated 01/29/21 revealed a circle had been made around the words stop Ibuprofen. Review of Resident #1's January 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Ibuprofen 800mg three times a day as needed for pain. -There was no documentation Ibuprofen 800mg was administered on 01/30/21-01/31/21. -There was no entry for Tramadol 50mg twice daily as needed. Review of Resident #1's February 2021 eMAR revealed: -There was an entry for Ibuprofen 800mg three times a day as needed for pain. -There was documentation Ibuprofen 800mg was administered on 02/02/21, 02/03/21, and 02/04/21. -There was no entry for Tramadol 50mg twice daily as needed. Observation of Resident #1's medication on hand on 02/02/21 at 11:15am revealed: -There was a punch card dispensed 01/22/21 for Ibuprofen 800mg administer one capsule three times daily as needed for pain; there were 31 of 40 tablets available for administration. -There was no Tramadol 50mg available for administration. Review of Resident #1's pharmacy dispensing records revealed:	{C 330}		

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{C 330}	Continued From page 34 -There were 40 tablets of Ibuprofen 800mg was dispensed on 12/11/20 and 01/22/21. -There were 40 tablets of Tramadol 50mg dispensed on 01/29/21. Interview with Resident #1 on 02/02/21 at 3:56pm revealed: -Her shoulder had been hurting her a lot and she had asked for pain medication. -The MA administered her pain medication on Friday night (01/29/21), twice on Saturday (01/30/21) and Sunday (01/31/21), and on Monday (02/01/21) morning before the MA left. -She thought the medication administered was Tramadol because her primary care provider (PCP) had ordered it on 01/29/21. -The medication administered helped "some", but her shoulder continued to hurt. -It was hurting now, especially when she raised her arm up. -She had asked the MA for a Tramadol today but was told the Tramadol was not on the medication cart. Telephone interview with a MA on 02/03/21 at 10:37am revealed: -She had worked at the facility from Friday, 01/29/21 at 5:00pm until Monday, 02/01/21 at 8:00am. -Resident #1 had asked for something for pain this weekend so she had administered Ibuprofen to Resident #1 several times. -She knew she had administered Ibuprofen on 01/29/21, 01/30/21 and 01/31/21, but did not recall if it was more than once a day. -Ibuprofen had not been discontinued in the eMAR so she thought it was okay to administer. Telephone interview with Resident #1 on 02/04/21 at 8:46am and 9:39am revealed:	{C 330}		

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{C 330}	Continued From page 35 -Her shoulder was still hurting. -She had not received the Tramadol her PCP had ordered. -The MA had given her Ibuprofen today, 02/04/21, and it had helped some, but "not a lot." -She thought her PCP had stopped the Ibuprofen when she saw him last week. -She had been having acid reflux for "a while." -She had gone to see her PCP a week or so ago (she did not recall the date) to discuss her acid reflux pain. -She reported she had a pain in her stomach after taking medications. -She also had acid reflux that caused her pain about an hour after she had eaten and then off and on after that. -Her PCP had changed her acid reflux medication, but the acid reflux pain was still bothering her. Review of Resident #1 physician summary dated 01/13/21 revealed; -Resident #1 was seen in the PCP office with complaints of having acid reflux "bad" and would like to get something to help with it. -Resident #1 was diagnosed with gastroesophageal reflux disease (GERD) and her current medication used to treat GERD was changed. Telephone interview with Resident #1's PCP on 02/04/21 at 8:53am revealed: -He had discontinued Resident #1's Ibuprofen because it was not effective as well as the negative impact the medication had on gastritis (Gastritis is an inflammation, irritation, or erosion of the lining of the stomach that could be caused by or triggered with the use of medication such as Ibuprofen), as well as long term use of Ibuprofen could cause kidney damage.	{C 330}		

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{C 330}	Continued From page 36 -Resident #1 was recently seen for complaints of acid reflux. -Tramadol was ordered for Resident #1 on 01/29/21 and the Ibuprofen should have been discontinued. -No one had contacted him about the Tramadol not being available to be administered, and Ibuprofen continued to be administered. -He would have wanted to know Resident #1's Tramadol was not available to be administered. -He would like to see Resident #1 in his office to be reevaluated. Telephone interview with a pharmacy technician for the facility's contracted pharmacy on 02/04/21 at 9:10am revealed: -An electronic prescription for Tramadol was received at the pharmacy on 01/29/21. -They did not receive an order to discontinue Resident #1's Ibuprofen. -They did not receive a copy of the physician's summary with directions to discontinue the Ibuprofen. -The staff at the facility could have discontinued the Ibuprofen in the eMAR and that would have prompted the pharmacy to ask for an order to discontinue the medication. Telephone interview with the facility's contracted registered nurse on 02/04/21 at 9:13am revealed: -She was aware there was an order to discontinue Resident #1's Ibuprofen. -The MA who was working on 01/29/21 called her and reviewed the physician summary. -She thought medication was typically not stopped until the new medication had been delivered. Telephone interview with a MA on 02/04/21 at 9:16am revealed:	{C 330}		

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{C 330}	Continued From page 37 -She was working on 01/29/21 when Resident #1 returned from her PCP appointment. -She did not read the physician's summary; she put the physician's summary in Resident #1's record. -She did not call the facility's contracted nurse and discuss the Ibuprofen. -She did not circle the words stop Ibuprofen and did not know who circled it. -She did not know she was supposed to fax the physician's summary to the pharmacy. -She could not discontinue medication in the eMAR, she thought the pharmacy was the only one who could do that. Telephone interview with the Administrator on 02/04/21 at 11:32am revealed: -She had not discontinued Resident #1's Ibuprofen in the eMAR because the medication ordered to replace the Ibuprofen had not been delivered. -Ibuprofen was the only pain medication Resident #1 had available and she wanted Resident #1 to be able to have something for pain if it was needed. -She did not know why Resident #1's PCP had changed the pain medication from Ibuprofen to Tramadol, but she thought it was because Tramadol was stronger. -She did not know Resident #1 had complained of acid reflux to her PCP. -She had not called the PCP about the Tramadol not being available to administer and get guidance on the Ibuprofen, but it was on her "to-do list." _____ The facility failed to administer medications as ordered including Resident #1 not receiving Tramadol for pain which resulted in the resident continuing to have unrelieved shoulder pain.	{C 330}		

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{C 330}	Continued From page 38 Ibuprofen was discontinued by the primary care provider (PCP) due to the side effects of the medication including gastritis. Ibuprofen continued to be administered and Tramadol was not administered for the resident's pain. The facility's failure was detrimental to the health and safety of the resident and constitutes an Unabated Type B Violation A plan of protection was requested in accordance with G.S. 131D-34 on 02/04/21 for this violation.	{C 330}		
{C 342}	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	{C 342}		

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{C 342}	Continued From page 39	{C 342}		

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the Medication Administration Records for 1 of 3 sampled residents (Resident #1).

The findings are:

Review of Resident #1's current FL-2 dated 12/30/20 revealed diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis, hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion.

a. Review of Resident #1's physician's order dated 01/29/21 revealed an order to stop Ibuprofen (a Nonsteroidal anti-inflammatory drug used to treat mild pain).

Review of Resident #1's January 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Ibuprofen 800mg three times a day as needed for pain.
-There was no documentation Ibuprofen 800mg was administered on 01/30/21-01/31/21.

Review of Resident #1's February 2021 eMAR revealed:
-There was an entry for Ibuprofen 800mg three times a day as needed for pain.
-There was documentation Ibuprofen 800mg was administered on 02/02/21, 02/03/21, and 02/04/21.

Observation of Resident #1's medication on hand on 02/02/21 at 11:15am revealed there was a punch card dispensed 01/22/21 for Ibuprofen 800mg administer one capsule three times daily

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{C 342}	Continued From page 40 as needed for pain; there were 31 of 40 tablets available for administration. Review of Resident #1's pharmacy dispensing records revealed 40 tablets of Ibuprofen 800mg were dispensed on 12/11/20 and 01/22/21. Based on observation, record reviews and interviews, Ibuprofen was documented as administered to Resident #1 three times and there were additional tablets that were administered but not documented on the eMAR. Interview with Resident #1 on 02/02/21 at 3:56pm revealed the medication aide (MA) administered her pain medication on Friday night (01/29/21), twice on Saturday (01/30/21), and Sunday (01/31/21), and on Monday (02/01/21) morning before the MA left. Telephone interview with a MA on 02/03/21 at 10:37am revealed: -She had worked at the facility from Friday, 01/29/21 at 5:00pm until Monday, 02/01/21 at 8:00am. -Resident #1 had asked for something for pain this weekend so she had administered Ibuprofen to Resident #1 several times. -She knew she had administered Ibuprofen on 01/29/21, 01/30/21 and 01/31/21, but did not recall if it was more than once a day. -She thought she had scanned Resident #1's Ibuprofen when she administered the medication, she did not know why her initials were not documented on the eMAR as administering the medication. Refer to the interview with the MA on 02/02/21 at 11:10am.	{C 342}		

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{C 342}	Continued From page 41 Refer to the telephone interview with the Administrator on 02/03/21 at 4:07pm. Refer to the second telephone interview with the Administrator on 02/04/21 at 9:39am. b. Review of Resident #1's signed physician's orders dated 12/04/20 revealed an order for Ipratropium 0.02% solution (a bronchodilator used to treat asthma) one vial four times a day as needed for wheezing. Review of Resident #1's administration history printed from the eMAR system on 02/02/21 revealed Ipratropium was administered 7 times between 01/20/21-01/29/21. Observation of Resident #1's medication on hand on 02/02/21 at 11:15am revealed: -A box of Ipratropium 0.02% vials was dispensed on 01/19/21; the box contained 2 foil packets and each packet contained 30 vials. -One packet had been opened and there were 16 of 30 available for administration. -The second foil packet had not been opened and there were 30 of 30 vials available for administration. Review of Resident #1's pharmacy dispensing records revealed the only dispensing for Ipratropium was on 01/19/21. Based on observation, record reviews and interviews, Ipratropium was documented as administered to Resident #1 seven times and there were additional vials that were administered but not documented on the eMAR. Interview with Resident #1 on 02/02/21 at 1:45pm revealed:	{C 342}		

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{C 342}	Continued From page 42 -She used her nebulizer "about 1-2 times" every day. -She knew she had used her nebulizer over the weekend (01/30/21-01/31/21) and Monday morning and Monday night (02/01/21). Telephone interview with a MA on 02/03/21 at 10:37am revealed: -She had administered Resident #1's Ipratropium nebulizer medication daily on 01/30/21, 01/31/21, and 02/01/21. -Her initials were not documented as administering the medication because she had not scanned Resident #1's Ipratropium. -She had not scanned Resident #1's Ipratropium when she administered the medication because there was nothing to scan. -She did not think about scanning the box that contained the Ipratropium packets to document administration of the medication. Telephone interview with the Administrator on 02/03/21 at 4:07pm revealed she last audited Resident #1's record in November 2020 Telephone interview with another MA on 02/04/21 at 7:41am revealed: -Resident #1 had used her Ipratropium nebulizer treatments last week. (He did not recall the dates). -He had scanned the medication before he administered it. -He did not know why it was not showing up in the eMAR. -He could not explain why there was no documentation with his name or initials showing he had scanned the Ipratropium medication. Refer to the interview with the MA on 02/02/21 at 11:10am.	{C 342}		

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{C 342}	Continued From page 43 Refer to the telephone interview with the Administrator on 02/03/21 at 4:07pm. Refer to the second telephone interview with the Administrator on 02/04/21 at 9:39am. _____ Interview with the MA on 02/02/21 at 11:10am revealed: -The pharmacy had provided the facility with a medication cart, computer and scanning system. -To administer medications, she pulled up a resident by name, scanned the medication that was scheduled to be administered and then popped the pill from the bubble pack into a cup to be administered to the resident. -The medication would not scan if it was not time for the medication, if you tried to scan the same medication twice or if there was no order. -The scan would document the medication was administered on the eMAR by the MA who was logged into the system. Telephone interview with the Administrator on 02/03/21 at 4:07pm revealed she last audited Resident #1's record in November 2020. Second telephone interview with the Administrator on 02/04/21 at 9:39am revealed: -She did not know the staff was not scanning medication before the medication was administered. -She put the "scanning system" in place to avoid medications not being documented when they were administered. -She expected every medication to be scanned and documented when the medication was administered.	{C 342}		

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{C 367}	Continued From page 44	{C 367}		
{C 367}	10A NCAC 13G .1008(a) Controlled Substances	{C 367}		

10A NCAC 13G .1008 Controlled Substances
(a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, record reviews, and interviews, the facility failed to ensure the record of controlled substances was maintained and reconciled accurately with the documented receipt and administration of controlled substances for 2 of 2 sampled resident (#1, #4) with an order for a sleeping medication and pain medication (#1) and anti-anxiety medication (#1, #4).

The findings are:

1. Review of Resident #1's current FL-2 dated 12/30/20 revealed diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis, hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion.

a. Review of Resident #1's physician's order dated 01/29/21 revealed an order for Tramadol 50mg (a narcotic used to treat moderate to severe pain) one tablet twice a day as needed.

Review of Resident #1's January 2021 electronic medication administration record (eMAR)

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revealed there was no entry for Tramadol 50mg twice daily as needed.

Review of Resident #1's medications on hand on 02/02/21 at 11:15am revealed there was no Tramadol 50mg available to be administered.

Telephone interview with a pharmacy technician for the facility's contracted pharmacy on 02/02/21 at 12:33pm revealed 40 tablets of Tramadol 50mg were dispensed and delivered to the facility for Resident #1 on 01/29/21.

Interview with a medication aide (MA) on 02/02/21 at 1:19pm revealed:
-Resident #1's Tramadol was not on the cart.
-Resident #1 had "just asked" for a Tramadol and she had looked on the cart and could not find the medication.
-She had never used the control lockbox and did not know if it contained medication.

Observation of the MA on 02/02/21 at 1:19pm revealed she tried every key on the medication cart key ring and the lockbox could not be opened to verify if the Tramadol was located inside the lockbox.

Observation of the Administrator's family member on 02/02/21 at 3:12pm revealed he tried every key on the medication cart key ring and the lockbox could not be opened.

Telephone interview with a pharmacy technician for the facility's contracted pharmacy on 02/02/21 at 2:10pm revealed:
-The pharmacy records indicated Resident #1's prescription of Tramadol 50mg was delivered to the facility on 01/29/21 and should have been signed for by the staff who accepted the delivery.

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{C 367}	Continued From page 46 -She did not have access to the driver's delivery records. Telephone interview with the Director of the Pharmacy for the facility's contracted pharmacy on 02/02/21 at 3:06pm revealed: -There were 40 tablets of Tramadol 50mg dispensed to Resident #1 and delivered on 01/29/21 to the facility and given to a named MA. -The policy was for the MA to review the medication delivered and if there was a discrepancy to call the pharmacy immediately. -When the medication was dispensed, it was scanned into a delivery tote. -If the medication was expected and was not delivered, the facility should have let the pharmacy know. Telephone interview with a MA on 02/02/21 at 4:07pm revealed: -She had worked at the facility from 01/29/21 at 5:00pm until 02/01/21 at 8:00am. -There had been several medication deliveries over the weekend, one on Friday night 01/29/21 and one on Saturday, 01/30/21. -She remembered seeing an order for Resident #1's Tramadol, but she did not recall the medication being delivered. -If Tramadol had been delivered to the facility, she would have scanned the medication into the cart. -She did not sign for any medication that was delivered. -She did not look inside the bag when it was delivered, she put the bag from the pharmacy in the medication cart drawer because it was delivered so late at night. Interview with a second MA on 02/02/21 at 4:27pm revealed no one ever told her what to do	{C 367}		

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with the delivery manifest, so she usually placed it on the desk in the office.

Interview with a third MA on 02/02/21 at 5:17pm revealed:
-No one told her what to do with the medication delivery manifest.
-The medications were delivered in a paper bag.
-She matched the medications listed on the manifest sheet with the contents of the bag when she had time, not immediately.
-She always matched the medications delivered with the sheet and if it did not match, she would call the pharmacy.
-She did not ever recall calling the pharmacy because the sheet always matched.

Observation of the top drawer of the medication cart on 02/02/21 at 4:30pm revealed several medications delivery manifest sheets; there was no delivery sheet dated 01/29/21.

Telephone interview with the Administrator on 02/02/21 at 5:30pm revealed:
-New orders were added to the eMAR by the pharmacy.
-When medications were delivered to the facility the MA should lock the medication in the bottom drawer of the medication cart.
-The morning MA knew to check the medication cart to see if any medications had been delivered the previous night and scan all new medications into the eMAR system as received.
-Once the medication was delivered to the facility and scanned in, she would approve the order so the medication could be administered.
-She did not know if Resident #1's Tramadol had been delivered to the facility or not.
-The pharmacy was usually, "pretty quick" and medication was delivered the day after it was

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ordered.
-She thought a named MA had found a discrepancy before between the medications delivered and the delivery manifest.

Telephone interview with another MA on 02/03/21 at 2:54pm revealed:
-She had found medications that had been delivered sitting on the desk in the paper bag they were delivered in.
-She knew there was one named MA who never did anything with the medication that was delivered except put the bag on the desk in the office.
-She had never had a discrepancy between medications delivered and the medication manifest.
-She had checked the medication cart today, 02/03/21, after talking with the Administrator and was not able to locate Resident #1's Tramadol.
-She had never used the lockbox in the medication cart, but she was able to open the lockbox today, 02/03/21, and there was no medication stored inside.
-The key to the lockbox was on the medication cart key ring; she did not know why no one else had been able to unlock the lockbox.

Telephone interview with the Account Manager from the facility's contracted pharmacy on 02/03/21 at 3:37pm revealed:
-A delivery manifest was provided and ideally should be signed and faxed to the pharmacy.
-A fax machine was provided to the facility, so the delivery manifest could be faxed.
-It was not uncommon for the first shift person to be the one who reviewed the medication delivered and fax the signed manifest sheet back to the pharmacy.
-We know what goes out on our end (the

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pharmacy) and the facility was responsible for checking to verify what was delivered.

Second interview with the Administrator on 02/02/21 at 5:50pm revealed she was concerned a control medication had been delivered to the facility and was unaccounted for.

Telephone interview with the Administrator on 02/03/21 at 4:27pm revealed:
-The MAs had been trained by the account manager from the facility's contracted pharmacy and knew what they were supposed to do.
-It was common sense if you signed for something that you knew what you had signed for.

b. Review of Resident #1's physician's order dated 12/30/20 revealed an order for Zolpidem Tartrate 5mg (a sedative used to treat insomnia) at bedtime.

Review of Resident #1's December 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for Zolpidem Tartrate 5mg daily with a scheduled administration time of 10:00pm.
-There was documentation Zolpidem Tartrate 5mg was administered at 10:00pm on 12/01/20-12/03/20 and 12/05/20-12/31/20.
-There was documentation on 12/04/20 Zolpidem Tartrate was not administered with the exception documented as withheld per primary care providers (PCP) orders.

Review of Resident #1's January 2021 eMAR revealed:
-There was an entry for Zolpidem Tartrate 5mg daily with a scheduled administration time of

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10:00 pm.
-There was documentation Zolpidem Tartrate 5mg was administered at 10:00pm on 01/01/21-01/31/21.

Review of Resident #1's February 2021 eMAR revealed:
-There was an entry for Zolpidem Tartrate 5mg daily with a scheduled administration time of 10:00 pm.
-There was documentation Zolpidem Tartrate 5mg was administered at 10:00pm on 02/01/21.

Review of Resident #1's controlled substance count sheet (CSCS) revealed:
-There was a CSCS provided by the pharmacy for Zolpidem Tartrate 5mg at bedtime with a dispense date of 10/02/20 for 28 tablets.
-There was documentation Zolpidem Tartrate 5mg was administered twelve times between 11/01/20-11/30/20.
-There was a CSCS provided by the pharmacy for Zolpidem Tartrate 5mg at bedtime with a dispense date of 11/02/20 for 28 tablets; there was no documentation on the log.
-There was a CSCS provided by the pharmacy for Zolpidem Tartrate 5mg at bedtime with a dispense date of 01/23/21 for 28 tablets; there was no documentation on the log.
-There was no other CSCS available for review.

Observation of Resident #1's medication on hand on 02/02/21 at 11:15am revealed:
-There was a bubble package labeled for Zolpidem Tartrate 5mg with instructions to take one tablet at bedtime with a dispense date of 12/14/20 with 2 of 30 tablets available for administration.
-There was a second bubble package labeled for Zolpidem Tartrate 5mg with instructions to take

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{C 367}	Continued From page 51 one tablet at bedtime with a dispense date of 01/23/21 with 16 of 22 tablets available for administration. Refer to the interview with a medication aide (MA) on 02/02/21 at 2:54pm. Refer to the interview with a second MA on 02/02/21 at 5:17pm. Refer to the telephone interview with a third MA on 02/03/21 at 10:33am. Refer to the telephone interview with a fourth MA on 02/04/21 at 7:41am. Refer to the telephone interview with the facility's registered nurse (RN) on 02/03/21 at 1:50pm. Refer to the telephone interview with the Account Manager from the facility's contracted pharmacy on 02/03/21 at 3:37pm. Refer to the telephone interview with the Administrator on 02/02/21 at 5:30pm. c. Review of Resident #1's physician's order dated 12/30/20 revealed an order for Lorazepam 1mg two times daily (an anti-anxiety medication). Review of Resident #1's December 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Lorazepam 1mg was administered at 8:00am from 12/01/20-12/31/20. -There was documentation Lorazepam 1mg was administered at 8:00pm on 12/01/20-12/03/20	{C 367}		

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and 12/05/20-12/31/20.
-There was documentation on 12/04/20 Lorazepam was not administered with the exception documented as withheld per primary care providers (PCP) orders.
-Lorazepam 1mg was documented as administered 57 times out of 62 opportunities.

Review of Resident #1's January 2021 eMAR revealed:
-There was an entry for Lorazepam 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Lorazepam 1mg was administered at 8:00am on 01/01/21, 01/04/21, 01/06/21, and 01/08/21-01/31/21.
-There was documentation Lorazepam 1mg was administered at 8:00pm on 01/02/21-01/31/21.
-There was documentation on 01/01/21 at 8:00pm and 01/05/21 and 01/07/21at 8:00pm Lorazepam was not administered with the exception documented as Resident #1 was out of the facility.
-Lorazepam 1mg was documented as administered 59 times out of 62 opportunities.

Review of Resident #1's February 2021 eMAR revealed:
-There was an entry for Lorazepam 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Lorazepam 1mg was administered at 8:00am on 02/01/21-02/02/21.
-There was documentation Lorazepam 1mg was administered at 8:00pm on 02/01/21.
-Lorazepam 1mg was documented as administered 2 times out of 3 opportunities.

Review of Resident #1's controlled substance count sheet (CSCS) revealed:

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{C 367}	Continued From page 53 -There was a CSCS provided by the pharmacy for Lorazepam 1mg twice daily with a dispense date of 10/02/20 for 66 tablets. -The first entry was 11/01/20 and the last entry was 12/01/20; there was no amount received documented or remaining amount documented. -Lorazepam was documented as administered 33 times out of 61 opportunities. -There was no other CSCS available for review. Observation of Resident #1's medication on hand on 02/02/21 at 11:15am revealed: -There was a bubble package labeled for Lorazepam 1mg with instructions to take one tablet twice daily with a dispense date of 01/06/21. -There were 16 of 22 tablets available for administration. Refer to the interview with a medication aide (MA) on 02/02/21 at 2:54pm. Refer to the interview with a second MA on 02/02/21 at 5:17pm. Refer to the telephone interview with a third MA on 02/03/21 at 10:33am. Refer to the telephone interview with a fourth MA on 02/04/21 at 7:41am. Refer to the telephone interview with the facility's registered nurse (RN) on 02/03/21 at 1:50pm. Refer to the telephone interview with the Account Manager from the facility's contracted pharmacy on 02/03/21 at 3:37pm. Refer to the telephone interview with the Administrator on 02/02/21 at 5:30pm.	{C 367}		

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{C 367}	Continued From page 54 2. Review of Resident #4's current FL-2 dated 03/06/20 revealed diagnoses included intellectual disability, schizophrenia, prostate cancer, iron deficiency anemia, and benign prostatic hyperplasia. Review of Resident #4's physician's order dated 09/25/20 revealed an order for Lorazepam 1mg (an anti-anxiety medication) one tablet three times daily as needed for anxiety and aggression. Review of Resident #4's controlled substance count sheet (CSCS) revealed: -There was a CSCS provided by the pharmacy for Lorazepam 1mg three times daily as needed for anxiety and aggression with a dispense date of 10/26/20 for 90 tablets. -There was documentation on 11/01/20 there were 46 tablets on hand, one tablet was administered, and the remaining amount was 45. -There was documentation Lorazepam 1mg was administered 17 times between 11/02/20 and 12/01/20. -The remaining amount documented on 12/01/20 was 27, leaving 2 tablets unaccounted for from 11/01/20-12/01/20. -There was no other CSCS available for review. Observation of Resident #4's medication on hand on 02/02/20 at 3:27pm revealed: -There was a prescription bottle labeled for Lorazepam 1mg to be administered three times daily as needed for anxiety and aggression. -The dispense date was 09/25/20 for 90 tablets. -The prescription bottle was empty. Telephone interview with the pharmacist at the facility's previous contracted pharmacy on 02/04/21 at 12:37pm revealed:	{C 367}		

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{C 367}	Continued From page 55	{C 367}		

-The last pharmacy dispensing of Resident #4's Lorazepam 1mg three times daily as needed for anxiety and aggression was dispensed on 09/25/20 for 90 tablets.
-The Lorazepam 1mg was ordered again on 10/26/20 but the order was canceled before it was delivered.
-The CSCS for Lorazepam 1mg dated 10/26/20 must have been sent to the facility, but the medication was not sent.

Review of Resident #4's electronic medication administration history for Lorazepam 1mg revealed:
-Lorazepam 1mg was documented as administered on 11/25/20, 12/17/20, 12/24/20, 12/25/20, 12/28/20, 01/05/21, 01/07/21, 01/12/21, 01/14/21, 01/16/21, 01/21/21, 01/22/21, 01/24/21, and 01/26/21.
-There was no other documentation Resident #4's Lorazepam 1mg had been administered.
-Lorazepam 1mg was documented as administered 14 times between 11/25/20 and 01/26/21.

Based on observation, interviews, and record reviews the medication count could not be reconciled for the Lorazepam dispensed on 09/25/20 without a current CSCS.

Refer to the interview with a medication aide (MA) on 02/02/21 at 2:54pm.

Refer to the interview with a second MA on 02/02/21 at 5:17pm.

Refer to the telephone interview with a third MA on 02/03/21 at 10:33am.

Refer to the telephone interview with a fourth MA

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{C 367}	Continued From page 56 on 02/04/21 at 7:41am. Refer to the telephone interview with the facility's registered nurse (RN) on 02/03/21 at 1:50pm. Refer to the telephone interview with the Account Manager from the facility's contracted pharmacy on 02/03/21 at 3:37pm. Refer to the telephone interview with the Administrator on 02/02/21 at 5:30pm. _____ Interview with a medication aide (MA) on 02/02/21 at 2:54pm revealed: -All medications were scanned prior to administration. -She had not used CSCS to document the administration of controlled substances since she started scanning medication that was administered. -She thought all the medications administered were documented in the eMAR and that was all the documentation that was needed. -She did not recall "exactly" when she had started using the scanning system, but it had "been a while." Interview with a second MA on 02/02/21 at 5:17pm revealed when the new computer system was put into place the control logs were no longer needed because documenting medications was done in the computer. (she did not recall when the computer eMAR system was implemented). Telephone interview with a third MA on 02/03/21 at 10:33am revealed she started using the computer system to document medication administration beginning "sometime in November 2020."	{C 367}		

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{C 367}	Continued From page 57 Telephone interview with a fourth MA on 02/04/21 at 7:41am revealed he did not have to document on the CSCS anymore because the computer picked up everything. (He did not recall when he started using the computer for documentation of medication administration). Telephone interview with the facility's registered nurse (RN) on 02/03/21 at 1:50pm revealed: -She thought, "everything on paper went away" when the new system was put into place. -She had not had anything to do with the new eMAR system training and only knew what the MAs had told her. Telephone interview with the Account Manager from the facility's contracted pharmacy on 02/03/21 at 3:37pm revealed: -She trained the staff on the eMAR system used by the facility. -CSCS were sent to the pharmacy with each controlled substance dispensed. -A blank CSCS was provided to the facility as part of the "welcome pack" in case the pharmacy did not send a CSCS when the medication was delivered to the facility. -She was not aware the staff was not documenting on the CSCS. -CSCS were standard and should have been used. -She had directed the staff to use the CSCS provided. -"Down the road" when staff was proficient on the eMAR system, she could teach them how to use the control inventory module but until then the staff would need to use the CSCS. Telephone interview with the Administrator on 02/02/21 at 5:30pm revealed: -The MAs had not been taught how to do the	{C 367}		

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{C 367}	Continued From page 58 medication inventory on the computer system and should have used the control logs. -She was not aware the control logs were not being completed. -She expected the MA to document the administration of controlled medications on the CSCS provided by the pharmacy. -She had not audited resident records since November 2020. _____ The facility failed to have an accurate accounting of the receipt and disposition of Resident #1's Tramadol, a controlled substance, which resulted in 40 Tramadol tablets being unaccounted for. The MAs did not use the controlled substance count sheets provided by the pharmacy to monitor the administration of controlled substances. These failures allowed for opportunities for potential drug diversion and risk for medication errors which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/04/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 21, 2021.	{C 367}		
C 368	10A NCAC 13G .1008 (b) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications	C 368		

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C 368	Continued From page 59 shall be under double lock. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure that the schedule II-controlled medication for 2 of 2 sampled residents (#1, #4) with an order for a sleeping medication (#1) and anti-anxiety medication (#1, #4) were stored under double-lock. The findings are: 1. Review of Resident #1's current FL-2 dated 12/30/20 revealed diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis, hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion. a. Review of Resident #1's physician's order dated 12/30/20 revealed an order for Zolpidem Tartrate 5mg (a sedative used to treat insomnia) at bedtime. b. Review of Resident #1's physician's order dated 12/30/20 revealed an order for Lorazepam 1mg two times daily (an anti-anxiety medication). Observation of Resident #1's medication on hand on 02/02/21 at 11:15am revealed Resident #1's Zolpidem Tartrate and Lorazepam were stored with all of Resident #1's medication in the second drawer from the bottom on the medication cart under one lock. 2. Review of Resident #4's current FL-2 dated 03/06/20 revealed diagnoses included intellectual disability, schizophrenia, prostate cancer, iron	C 368		

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C 368	Continued From page 60 deficiency anemia, and benign prostatic hyperplasia. Review of Resident #4's physician's order dated 09/25/20 revealed an order for Lorazepam 1mg (an anti-anxiety medication) one tablet three times daily as needed for anxiety and aggression. Observation of Resident #4's medication on hand on 02/02/20 at 3:27pm revealed Resident #4's Lorazepam was stored with all of Resident #4's medication in the second drawer from the top on the medication cart under one lock. Interview with a medication aide (MA) on 02/02/21 at 11:33am revealed: -The medication cart was usually kept in the hall. -Sometimes they kept the medication cart in a room, but "usually we just keep it in the hall." -They did not have a different area on the medication cart for control medications to be double locked. -All medications were kept on the medication cart and the cart was locked. Observation on 02/02/21 at 1:19pm of the facility's medication cart revealed: -The medication cart was sitting in the hallway outside of the office door. -The medication cart had four drawers. -The medication cart was locked. -The medication cart contained a separate locked drawer for controlled medications; it was located in the second drawer from the top. Interview with a MA on 02/02/21 at 1:19pm revealed she had never used the control lockbox on the medication cart and did not know if it contained medication.	C 368		

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C 368	Continued From page 61 Observation of the MA on 02/02/21 at 1:19pm revealed she tried every key on the medication cart key ring and the lockbox could not be opened to verify if a controlled medication was located inside the lockbox. Observation of the Administrator's family member on 02/02/21 at 3:12pm revealed he tried every key on the medication cart key ring and the lockbox could not be opened. Telephone interview with the Administrator on 02/02/21 at 5:30pm revealed the lockbox had never worked and someone from the pharmacy would be bringing a new key. Interview with a second MA on 02/02/21 at 5:17pm revealed: -Controlled medication should be kept in the lockbox on the medication cart. -She had opened the lockbox before, she thought it was one-day last week. -The controlled medication bubble packs would not fit in the lockbox, "just prescription bottles." -The controlled medication may have been mixed in with all the medication, but it should have been in the lockbox. Telephone interview with the facility's contracted registered nurse (RN) on 02/03/21 at 1:50pm revealed: -Controlled medication should be double locked. -She did not know if the MAs were using the lockbox within the medication cart. -She knew there was an area in the medication cart to lock controlled medication. -She would have thought the MAs would have used the lockbox to store controlled medication. Telephone interview with a third MA on 02/03/21	C 368		

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C 368	Continued From page 62 at 2:54pm revealed: -They had not been trained to use the lockbox on the medication cart. -She had never used the lockbox in the medication cart, but she was able to open the lockbox today, 02/03/21, and there was no medication stored inside. -The key to the lockbox was on the medication cart key ring; she did not know why no one else had not been able to unlock the lockbox. -The medication cart was always kept in the hallway. Telephone interview with the Account Manager from the facility's contracted pharmacy on 02/03/21 at 3:37pm revealed: -She trained the MAs on how to use the medication cart. -She always instructed the MAs to use the control lockbox so controlled medication was double locked. -Having a control lockbox within the medication cart was one of the reasons she had provided the facility with the medication cart. -She was not aware the MAs were not using the control lockbox to store the controlled medication. -She made sure the staff had a key to the control lockbox. Telephone interview with the Administrator on 02/04/21 at 4:07pm revealed: -Controlled medications were supposed to be double locked. -She had told the MAs the medication cart was supposed to be locked in a designated room after every medication pass. -She had her family member install a new door lock on the designated room, so the medication cart could be locked in the room. -She did not know the medication cart had not	C 368		

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C 368	Continued From page 63 been locked in the designated room until she arrived at the facility on 02/02/21 and saw the cart in the hallway. -She had told the MAs "time and time again" to put the medication cart in the designated room and to lock the door.	C 368		
C 374	10A NCAC 13G .1008(h) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, the local law enforcement agency and Health Care Personnel Registry as required by state law and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to report suspected drug diversions of controlled substances to the Health Care Personnel Registry for 1 of 2 sampled residents who was prescribed Hydrocodone (#1). The findings are: Review of Resident #1's current FL-2 dated 12/30/20 revealed diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis, hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion. Review of Resident #1's physician's order dated 01/29/21 revealed an order for Tramadol 50mg (a narcotic used to treat moderate to severe pain) one tablet twice a day as needed.	C 374		

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C 374	Continued From page 64 Review of Resident #1's January 2021 electronic medication administration record (eMAR) revealed there was no entry for Tramadol 50mg twice daily as needed. Review of Resident #1's medications on hand on 02/02/21 at 11:15am revealed there was no Tramadol 50mg available to be administered. Telephone interview with a pharmacy technician for the facility's contracted pharmacy on 02/02/21 at 12:33pm revealed 40 tablets of Tramadol 50mg were dispensed and delivered to the facility for Resident #1 on 01/29/21. Interview with a medication aide (MA) on 02/02/21 at 1:19pm revealed: -Resident #1's Tramadol was not on the cart. -Resident #1 had "just asked" for a Tramadol and she had looked on the cart and could not find the medication. Telephone interview with a pharmacy technician for the facility's contracted pharmacy on 02/02/21 at 2:10pm revealed: -The pharmacy records indicated Resident #1's prescription of Tramadol 50mg was delivered to the facility on 01/29/21 and should have been signed for by the staff who accepted the delivery. -She did not have access to the driver's delivery records. Telephone interview with the Director of the Pharmacy for the facility's contracted pharmacy on 02/02/21 at 3:06pm revealed: -There were 40 tablets of Tramadol 50mg was dispensed to Resident #1 and delivered on 01/29/21 to the facility and given to a named MA. -There was also a nose spray dispensed and delivered at the same time for another resident.	C 374		

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C 374	Continued From page 65 -The policy was for the MA to review the medication delivered and if there was a discrepancy to call the pharmacy immediately. -When the medication was dispensed, it was scanned into a delivery tote. -If the medication was expected and was not delivered, the facility should have let the pharmacy know. Observation of the medication cart on 02/02/21 at 3:15pm revealed the nose spray was on hand that was dispensed and delivered to the facility on 01/29/21 with the Tramadol delivery from the pharmacy. Telephone interview with a MA on 02/02/21 at 4:07pm revealed: -She had worked at the facility from 01/29/21 at 5:00pm until 02/01/21 at 8:00am. -There had been several medication deliveries over the weekend, one on Friday night 01/29/21 and one on Saturday, 01/30/21. -She remembered seeing an order for Resident #1's Tramadol, but she did not recall the medication being delivered. -If Tramadol had been delivered to the facility, she would have scanned the medication into the cart. -She did not sign for any medication that was delivered. -She did not look inside the bag when it was delivered, she put the bag from the pharmacy in the medication cart drawer because it was delivered so late at night. Telephone interview with the Administrator on 02/02/21 at 5:50pm revealed: -She was concerned a control medication had been delivered to the facility and was unaccounted for.	C 374		

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C 374	Continued From page 66 -She would need to contact the HCPR and complete a 24-hour report. Telephone interview with a representative with the HCPR on 02/03/21 at 3:32pm revealed a 24-hour report had not been submitted for the facility or named MA. Telephone interview with the Administrator on 02/03/21 at 4:07pm revealed: -She was having difficulty saying what happened with the Tramadol because there was no proof the driver delivered the medication to the facility. -"I cannot say what happened." -My common sense tells me it was the MA, but I cannot say "definitely." -She had started working on the 24-hour report but had not had time to submit it to the HCPR. -She would submit the 24-hour report to the HCPR today, 02/03/21. Telephone interview with a representative with the HCPR on 02/04/21 at 8:12am revealed a 24-hour report had not been submitted for the facility or named MA. Telephone interview with the Administrator on 02/04/21 at 11:32am revealed: -She was working on the 24-hour report, "I have completed it." -She had lost track of time and "it was going against her anyway." -She would fax a copy of the completed 24-hour report to the surveyor and to the HCPR. Review of fax from the Administrator received on 02/05/21 at 3:30am revealed: -The complaint intake and healthcare personnel investigation report was completed. -The date of the incident was 01/29/21 and she	C 374		

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C 374	Continued From page 67 became aware of the incident on 02/02/21 at 2:00pm. -The 24-hour report was signed by the Administrator on 02/03/21. Telephone interview with a representative with the HCPR on 02/05/21 at 9:10am revealed a 24-hour report had not been submitted for the facility or named MA.	C 374		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: FOLLOW UP TO A TYPE A2 VIOLATION	C 612		

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C 612	Continued From page 68 The Type A2 Violation was abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic regarding recommended infection prevention and control practices to reduce the risk of transmission and infection as related to not properly screening of staff and visitors. The findings are: Review of the NC DHHS Guidance for Smaller Residential Settings Regarding Visitation, Communal Dining, Group and Outside Activities, last updated 06/26/20 revealed: -Each facility must have a written plan which outlines their facility's policy on visitation, communal dining, and group/outside activities. -The facility must have a plan that include procedures for conducting daily screening for temperature check, presence of symptoms, and known exposure to COVID-19 of all residents and staff, particularly those returning from extended visits or time outside of the home. -Screen visitors for symptoms of illness, known exposure to COVID-19, Review of the CDC guidelines for the prevention and spread of the coronavirus disease in LTC facilities, last updated 11/20/20, revealed: -Screen all health care personnel at the beginning of their shift for fever and symptoms of COVID-19	C 612		

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C 612	Continued From page 69	C 612		

and document absence of symptoms consistent with COVID-19.
-Screen all visitors for the presence of fever and symptoms consistent with COVID-19 when they enter the building.

Review of the facility's COVID-19 policy dated 10/27/20 revealed visitors were required to be screened for symptoms of illness, known exposure to COVID-19 and could be refused visitation based upon the screening.

1. Observation of the inside entrance to the facility on 02/02/21 at 9:15am revealed:
-The survey team was temperature checked and requested to sign in and document their temperatures by the medication aide (MA), but they were not screened for questions.
-There was a piece of notebook paper on a table for the survey team to sign in on; there were no screening questions on the sheet.
-There was a sign out log for the residents, but no other paperwork was at the entrance or on the table.

Observation of a visitor on 02/02/21 at 5:14pm revealed the visitor came into the facility and went into the bathroom without signing in, being screened for temperature or answering screening questions by the staff.

Observation of the inside entrance to the facility on 02/02/21 at 5:15pm revealed:
-There was a plain folder on the table by the door.
-The folder had sign in sheets for visitors; the sheets had pre-screening questions on them.
-The sheets were filled with signatures of visitors and residents and their temperatures; there were no blank spaces for any additional visitor sign ins.

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C 612	Continued From page 70 Review of the pre-screening sign sheets on 02/02/21 revealed there were no pre-screening logs for the months of January 2021 or February 2021. Interview with a MA on 02/02/21 at 5:19pm revealed: -The Administrator told her to put the screening sheets [log] back on the table (02/02/21); she did not know there were no blank screening sheets in the folder. -She did not know where the blank screening and sign in sheets were; she thought they were in the office somewhere. Telephone interview with the Administrator on 02/04/21 at 8:43am revealed: -Staff were also instructed to call her before visitors were allowed into the facility; she wanted to conduct the screenings over the phone. -She instructed the staff to take temperatures and interview each visitor before they came into the facility. -She began to use the pre-screening questions in November 2020 and that is when she told to staff to be sure temperatures were taken, questions asked, and visitors signed in before entering the facility. -She saw the piece of lined paper that was being used to sign in when she was at the facility on 02/02/21 and told the MA to put the screening sheets [log] on the table; she did not know there were no blank sheets available. 2. Observation of the entrance on 02/02/21 at 12:23pm revealed: -The Administrator entered the facility and walked to the staff bathroom after she was unable to locate the thermometer. -The Administrator washed her hands while in the	C 612		

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C 612	Continued From page 71 bathroom. -The Administrator then stepped into the foyer while she continued to look for the thermometer. -The Administrator walked into the medication room and asked the medication aide (MA) where the thermometer was. -The Administrator told the MA to keep the thermometer by the door. -The Administrator did not answer screening questions or sign in. Review of the pre-screening sign sheets on 02/02/21 revealed: -There were no staff signatures for January 2021 or February 2021 on th pre-screening. -There were no pre-screening logs for the months of January 2021 or February 2021. Review of the staff temperature log on 02/03/21 reveled the staff used the electronic medical administration (eMAR) system to log their temperatures. Interview with a MA on 02/02/21 at 5:19pm revealed: -The Administrator took her own temperature on 02/02/21, but she did not sign in because there were not any sheets to sign in on. -The Administrator told her to put the screening sheets [log] back on the table; she did not know there were no blank screening sheets in the folder. -She did not know where the blank screening and sign in sheets were; she thought they were in the office somewhere. Interview with a second MA on 02/02/21 at 5:28pm revealed: -She took her temperature before each shift and documented it into the eMAR.	C 612		

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C 612	Continued From page 72 -She did not answer the prescreen questions that were on the sign in sheet at the entrance of the facility. -She was not told by the Administrator to answer questions but just to take and document her temperature. Telephone interview with the Administrator on 02/04/21 at 8:43am revealed: -She instructed the staff to prescreen each other and to make sure the temperatures were taken, and questions answered and documented. -She began to use the pre-screening questions in November 2020 and that is when she told to staff to be sure temperatures were taken, questions asked, and to sign in before entering the facility. -She saw the piece of lined paper that was being used to sign in when she was at the facility on 02/02/21 and told the MA to put the screening sheets [log] on the table; she did not know there were no blank sheets available.	C 612		
{C 912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to adult care home medication aides training and competency evaluation requirements.	{C 912}		

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{C 912}	Continued From page 73 The findings are: Based on interviews and record reviews, the facility failed to ensure 4 of 4 staff sampled who administered medications had completed a 5, 10 or 15 hour mandated medication aide training, completed their medication clinical skills competency validation prior to administering medications (Staff A, B, C, and D), and successfully completed the required state examination (Staff D). [Refer to Tag C935 G.S. § 131D-4.5B(b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Type Unabated B Violation)].	{C 912}		
{C 914}	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to ensure each resident was free of neglect related to management and other staff, medication administration, and controled substances. The findings are 1. Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules related to controlled substances, medication administration, infection prevention and control program related to COVID-19, test for tuberculosis, adult care home medication aide training and competency evaluation	{C 914}		

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{C 914}	Continued From page 74 requirements, housekeeping and furnishing, building service equipment, resident rights, personal care and supervision, and staff qualifications. [Refer to Tag C185 10A NCAC 13G .0601(a) Management and Other Staff (Type B Violation)]. 2 . Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered to 1 of 3 sampled residents (#1) including a Nonsteroidal anti-inflammatory drug used to treat mild pain and a narcotic used to treat moderate to severe pain. [Refer to Tag C330 10A 10A NCAC 13G .1004(a) Medication Administration (Type Unabated B Violation)]. 3. Based on observations, record reviews, and interviews, the facility failed to ensure the record of controlled substances was maintained and reconciled accurately with the documented receipt and administration of controlled substances for 2 of 2 sampled resident (#1, #4) with an order for a sleeping medication and pain medication (#1) and anti-anxiety medication (#1, #4). [Refer to Tag C367 10A NCAC 13G .1008(a) Controlled Substances (Type B Violation)].	{C 914}		
{C935}	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	{C935}		

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{C935}	Continued From page 75 medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION	{C935}		

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{C935}	Continued From page 76 Based on these findings, the previous Type B Violation was not abated. Based on interviews and record reviews, the facility failed to ensure 4 of 4 staff sampled who administered medications had completed a 5, 10 or 15 hour mandated medication aide training, completed their medication clinical skills competency validation prior to administering medications (Staff A, B, C, and D), and successfully completed the required state examination (Staff D). 1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 09/23/20. -There was documentation signed by a Registered Nurse (RN) that Staff A had completed the 15-hour medication training on 12/31/20. -There was no documentation Staff A completed the medication clinical skills competency validation. -There were no new hire forms on file prior to 09/23/20. -There was no documentation Staff A had passed the written medication aide (MA) exam. Interview with Staff A on 02/02/21 at 4:35pm revealed: -She had not taken the state required MA exam and she had not signed up to take the test. -She was not sure what the medication clinical skills competency validation was but thought she had completed it during a training on 12/31/20. -Someone from the pharmacy the had conducted the training on 12/31/20. -She did not remember anyone observing her pass medications and checking off on a list. -She had administered medication to residence	{C935}		

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{C935}	Continued From page 77 since she started working in the facility. Review of a resident's electronic medication administration record (eMAR) for December 2020 revealed Staff A had administered mediation 10 days in December 2020. Review of a resident's eMAR for January 2021 revealed Staff A had administered medications 10 days in January 2021. Refer to the telephone interview with the Account Manager from the facility's contracted pharmacy on 02/03/21 at 3:48pm. Refer to the telephone interview with the pharmacy's sub contracted Registered Nurse (RN) on 02/03/21 at 3:48pm. Refer to the telephone interview with the Administrator on 02/04/21 at 8:29am. 2. Review of Staff B's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff B was hired on 09/21/20. -There was documentation signed by a Registered Nurse (RN) that Staff B had completed the a 5 hour medication aide training on 12/13/20 and a 15-hour medication training on 12/31/20. -There was no documentation Staff B completed the medication clinical skills competency validation. Telephone interview with Staff B on 02/03/21 at 2:10pm revealed: -She had completed the 15-hour medication aide training and had also completed the medication clinical skills competency validation on 12/31/20. -The pharmacy [representative] and the nurse	{C935}		

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{C935}	Continued From page 78 conducted the training. -The RN that conducted the training on 12/31/20 did not watch her administer mediation to residents or ask her to demonstrate administering medications to residents at the facility. -She had been administering medication to the residents since she had been working in the facility in September 2020. Review of a resident's electronic medication administration record (eMAR) for December 2020 revealed Staff A had administered mediation 5 days between 12/01/20 and 12/13/20. Review of a resident's eMAR for January 2021 revealed Staff B had administered medications 10 days in January 2021. Refer to the telephone interview with the Account Manager from the facility's contracted pharmacy on 02/03/21 at 3:48pm. Refer to the telephone interview with the pharmacy's sub contracted Registered Nurse (RN) on 02/03/21 at 3:48pm. Refer to the telephone interview with the Administrator on 02/04/21 at 8:29am. 3. Review of Staff C's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff C was hired on 08/30/20. -There was documentation signed by a Registered Nurse (RN) that Staff C had completed a 5 hour medication aide training on 12/14/20 and the 15-hour medication training on 12/31/20. -There was no documentation Staff C completed the medication clinical skills competency validation.	{C935}		

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{C935}	Continued From page 79 Telephone interview with Staff C on 02/04/21 at 7:47pm revealed: -He thought he had completed a medication clinical skills competency validation at a 12/31/20 training, but she could not remember. -He had always administered medication to residents at the facility because he had already passed the medication aide (MA) exam years ago. -He did not have a RN watch him administer medications to the residents at the facility. Review of a resident's electronic medication administration record (eMAR) for December 2020 revealed Staff A had administered mediation 5 days between 12/01/20 and 12/14/20. Review of a resident's eMAR for January 2021 revealed Staff C had administered medications 10 days in January 2021. Refer to the telephone interview with the Account Manager from the facility's contracted pharmacy on 02/03/21 at 3:48pm. Refer to the telephone interview with the pharmacy's sub contracted Registered Nurse (RN) on 02/03/21 at 3:48pm. Refer to the telephone interview with the Administrator on 02/04/21 at 8:29am. 4. Review of the facility's personnel records revealed Staff D did not have a personnel record. Review of a resident's electronic medication administration record (eMAR) for December 2020 revealed Staff D had administered medications 6 days in December 2021.	{C935}		

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{C935}	Continued From page 80 Review of a resident's eMAR for January 2021 revealed Staff D had administered medications 15 days in January 2021. Telephone interview with Staff D on 02/04/21 at 11:39am revealed: -She had not completed the medication clinical skills competency validation for the facility, and she had not been asked to provide any documents for her record. -She worked alone on the weekends she worked and she administered medications to the residents at the facility. -She had been administering medications since she worked at the facility. -She already had her training and had passed her MA and had been working as an MA. -She never provided the Administrator with any documents. Telephone interview with the Administrator on 02/03/21 at 1:15pm revealed: -Staff D had an application and some of her trainings but she did not have a full record at the facility. -She knew Staff D had everything she needed because she worked at another facility as a MA and she had to have everything she needed to work there. Refer to the telephone interview with the Account Manager from the facility's contracted pharmacy on 02/03/21 at 3:48pm. Refer to the telephone interview with the pharmacy's sub contracted Registered Nurse (RN) on 02/03/21 at 3:48pm. Refer to the telephone interview with the	{C935}		

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	FCL093012	A. BUILDING: _____ B. WING _____	R 02/05/2021

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{C935}	Continued From page 81 Administrator on 02/04/21 at 8:29am. _____ Telephone interview with the Account Manager from the facility's contracted pharmacy on 02/03/21 at 3:48pm revealed: -She had trained the facility staff on the use of the new medication cart and the electronic medication administration record (eMAR) system but she had not conducted any other training. -The pharmacy sub contracted a third party to train medication aides (MAs); the third party was a Registered Nurse (RN). -She and the RN were at the facility on 12/31/20 and the completed the 15-hour medication aide training but did not do the medication clinical skills competency validation for the facility. -The facility could arrange with the pharmacy to have a RN complete the medication clinical skills competency validation for the facility's MAs. -To date, the facility had not scheduled the medication clinical skills competency validation for the facility's MAs. Telephone interview with the pharmacy's sub contracted Registered Nurse (RN) on 02/03/21 at 3:48pm revealed: -She had gone over the 14 or 17 points on the medication skills competency list as part of the 15-hour medication aide training that was completed on 12/31/20. -She had not done a one on one observation or discussion with the facility medication aides (MAs) specific to the facility and she had not signed off on the medication clinical skills competency validation for any of the MAs at the facility. -She would have to go back to the facility to complete the medication clinical skills competency validation but that had not been scheduled yet.	{C935}		

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{C935}	Continued From page 82 Telephone interview with the Administrator on 02/04/21 at 8:29am revealed: -She knew what the medication clinical skills competency validation was and that it needed to be signed off on by a Registered Nurse (RN) or Pharmacist and the medication aides (MAs). -She knew the medication clinical skills competency validation needed to be signed off in order to administer medication and prior to administering mediation to residents. -She had not scheduled the RN from the pharmacy to conduct the validation yet because she did not want to overwhelm the MAs; they had done a lot of training already with a new medication cart, electronic medication administration record (eMAR) system and the 15-hour medication aide training. -She thought two of the MAs had already completed the medication clinical skills competency validation for the facility in September 2020. Refer to Tag C330 10A NCAC 13G .1004(a) Medication Administration. Refer to Tag C367 10A NCAC 13G .1008(a) Controlled Substances. Refer to Tag C342 10A NCAC 13G .1004(j) Medication Administration. Refer to Tag C368 10A NCAC 13G .1008(b) Controlled Substances. Refer to Tag C374 10A NCAC 13G .1008(h) Controlled Substances. _____ The facility failed to ensure 4 of 4 sampled staff who administered medications were competency	{C935}		

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{C935}	Continued From page 83 validated and completed the 5, 10, 15 hour mandated trainings prior to administering mediations. The facility failure resulted in medication errors and the disposition of controlled substances not being maintained at all times was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility was provided a plan of protection in accordance with G.S. 131D-34 on 02/04/21 for this violation.	{C935}		
{C992}	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home 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	{C992}		

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{C992}	Continued From page 84 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. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation is abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 1 of 4 sampled staff (Staff D) prior to hire. The findings are: Review of the facility's personnel records revealed Staff D did not have a personnel record. Telephone interview with Staff D on 02/04/21 at 11:39am revealed she had not had a screening for controlled substances since she began working at the facility in September 2020 or October 2020 as a medication aide (MA). Telephone interview with the Administrator on 02/04/21 at 8:25am revealed: -Staff D should have had a partial record at the facility, but she could not find Staff D's personel record. -She had not done a screening for the presence	{C992}		

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{C992}	Continued From page 85 of controlled substances for Staff D. -Staff D worked sporadically so it was hard to get information from her. -She was going on "faith" that everything was done for Staff D for another facility she worked at.	{C992}		