STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078098	A. BUILDING: _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 7	2133 PRESTON ROAD MAXTON, NC 28364

(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 and the Robeson County Department of Social Services conducted an annual survey on 08/25/16.	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 assure walls and floors were kept clean and in good repair for 2 of 2 common resident bathrooms, one resident room, the hallway, and the dining room. The findings are: Observation of the common bathroom on 08/25/16 at 10:33 a.m. revealed: -There was black scuff marks on the wall beside the toilet. -The scuff marks were 2 to 3 feet long. -There were multiple brown burn marks on the vinyl flooring around the toilet. Observation of the Room #6 on 08/25/16 at 10:35 a.m. revealed: -There were multiple scratch marks on the wall near the head of the bed. -The paint was peeled away around the scratch marks.	C 074		

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C 074	Continued From page 1 Interview with a resident in Room #6 on 08/25/16 at 10:35 a.m. revealed he did not know how long the scratch marks had been on the wall or what caused the scratch marks. Observation of the handicapped accessible common bathroom on 08/25/16 at 10:39 a.m. revealed: -There were long black scuff marks running down the length of the wall near the sink that were about 5 to 6 feet long. -The paint was missing up and down the edges of the scuff marks. -There was a layer of green paint exposed along the scratch marks from a previous coat of paint under the current white paint. Observation of the hallway on 08/25/16 at 10:50 a.m. revealed: -There were multiple black scuff marks running down the entire length of the left side of the hallway from Room 1 down to Room 4. -The black scuff marks were on the lower portion of the wall near the floor. -The paint was peeling or missing around the scuff marks. -The bottom third of the doors to the rooms on the left and right side of the hallway had multiple black scuff marks. Observation of the dining room on 08/25/16 at 10:55 a.m. revealed: -There were black scuff marks and dents on the walls in the right corner of the dining room. -The marks were about 4 feet up the wall and spanned anywhere from 1 to 2 feet in width. Interview with a medication aide on 08/25/16 at 2:20 p.m. revealed: -The walls in the facility have been scratched for	C 074		

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C 074	Continued From page 2 years. -The scratch marks are caused by the wheelchairs. -They currently have two residents who use wheelchairs including one resident who was legally blind. -They also have a resident who uses a geri-chair in the dining room and staff have pushed the geri-chair against the wall causing the scratch marks on the wall in the dining room. -Some painting had been done in the facility a while back by the previous facility owners. -There had been no painting done since the change of ownership in January 2016. Interview with the live-in staff person on duty on 08/25/16 at 2:50 p.m. revealed: -She had worked at the facility for about 2 years. -The scratch marks had been on the wall for at least a couple of months. -The marks were caused by the wheelchairs. -The burn holes have been on the vinyl floor since she started working here. Interview with the Supervisor on 08/25/16 at 5:45 p.m. revealed: -The Administrator was at an appointment and unable to be at the facility today. -She thought the Administrator was in the process of making plans to do some painting in the facility. -She would check with the Administrator.	C 074		
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	C 147		

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C 147	Continued From page 3 accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 4 staff (C) sampled had a criminal background check in accordance with G.S. 114-19.10 and 131D-40. The findings are: Review of Staff C's personnel file revealed: -Staff C was hired on 03/18/16. -Staff C was hired as resident care / nursing assistant, medication aide, and live-in staff. -There was documentation of a consent for a criminal background check by Staff C signed and dated 03/29/16. -There was no documentation of a criminal background check on file for Staff C. Interview with a medication aide on duty on 08/25/16 revealed Staff C was another medication aide who worked at the facility but Staff C was not working today. Staff C was unavailable for interview on 08/25/16. Interview with the Supervisor on 08/25/16 at 5:45 p.m. revealed: -The Administrator was at an appointment and unable to be at the facility today. -The Administrator and the Supervisor were responsible for the personnel files. -Staff C worked as a medication aide at the facility. -Criminal background checks should have been done for all staff upon hire but she could not locate one for Staff C. -She would contact the Administrator regarding	C 147		

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C 147	Continued From page 4 Staff C's criminal background check. No further information regarding the criminal background check for Staff C was provided by the end of the survey on 08/25/16.	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: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 resident (#1) who smoked and was blind and had cigarette burn holes on his clothing, shoes, and wheelchair. The findings are: Review of Resident #1's current FL-2 dated 10/08/15 revealed the resident's diagnoses included stage 5 kidney disease (on dialysis), diabetes, hypertension, blindness, history of right above knee amputation, peripheral neuropathy, hyperlipidemia, and chronic pain. Review of Resident #1's Resident Register revealed: -The resident was admitted to the facility on 03/31/14. -The resident was noted to have a personal habit of smoking. -The resident's memory was adequate.	C 243		

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C 243	Continued From page 5	C 243		

Review of Resident #1's current assessment and care plan dated 04/01/16 revealed:
-The resident was non-ambulatory and used a wheelchair.
-The resident had limited strength in his upper extremities.
-The resident required limited assistance with eating, toileting, and transferring.
-The resident required extensive assistance with bathing, dressing, and grooming.
-The resident required total assistance with ambulation.
-The resident was sometimes disoriented but his memory was adequate.

Observations of Resident #1 on 08/25/16 at 12:30 p.m. and 4:40 p.m. revealed:
-The resident had a cigarette burn hole on the inside left leg of his blue jean shorts.
-The resident had 3 cigarette burn holes on the top of his left bedroom shoe.
-There were multiple burn holes in the seat of the resident's wheelchair.

Interview with the medication aide on 08/25/16 at 2:20 p.m. revealed:
-Resident #1 was a smoker and he smoked outside independently.
-The resident was oriented and could smoke by himself.
-Staff started keeping Resident #1's cigarette lighter and cigarettes at night a few months ago because they thought he may have been smoking in the bathroom.
-Resident #1 was blind but he was able to self-propel his wheelchair in the facility and outside to smoke.
-Resident #1 was her family member and he had always been able to light and smoke his cigarettes without assistance even though he was

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C 243	Continued From page 6	C 243		

blind.
-Staff did not supervise Resident #1 when he smoked.
-She was aware he had some cigarette burn holes on his clothing from dropping cigarettes.
-She thought the burn holes had been there a while.

Interview with Resident #1 on 08/25/16 at 4:42 p.m. revealed:
-He was legally blind in both eyes and could not see anything.
-He said "it's dark" (referring to his vision).
-He could self-propel his wheelchair in the facility and outside on the porch.
-He smokes independently outside on the porch every day about 1 to 2 hours total.
-The facility staff kept his cigarette lighter at night and he got it back in the mornings.
-He did not need help smoking but staff would help if he needed it.
-The cigarette burn holes in his wheelchair had been there a while, at least "a year or two".
-He used to drop cigarettes and the last time he dropped one was about 2 months ago.
-He denied having any burns on his skin.
-He was aware of the cigarette burn holes in his clothes and on his shoes but was not sure how long they had been there.

Interview with the live-in staff on duty on 08/25/16 at 4:55 p.m. revealed:
-The burn holes in Resident #1's wheelchair were there when she started working at the facility about 2 years ago.
-She had seen the burn holes on top of Resident #1's bedroom shoes and asked him about it.
-The resident told her he did not know what happened but he must have dropped a cigarette on the shoes.

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C 243	Continued From page 7 -She had also seen cigarette burn holes in the resident's clothes too. -She could not give a timeframe for when she first saw the burn holes in the resident's shoes or clothing. -No one supervised Resident #1 when he was outside smoking. -She had seen him light his cigarettes before and he did not seem to have any problems lighting the cigarette even though the resident was blind. -She had never actually seen the resident drop any cigarettes. Interview with the Supervisor on 08/25/16 at 5:45 p.m. revealed: -She was aware Resident #1 smoked outside independently. -She was not aware of any cigarette burn holes on his clothing or wheelchair. -She was not aware the resident had dropped any cigarettes while smoking. -She would have staff start going outside with the resident to supervise him while he smoked for his safety.	C 243		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations, interviews, and review of the facility's Activity Program calendar, the facility failed to develop a program of activities designed to promote the residents' active involvement.	C 288		

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C 288	Continued From page 8 The findings are: Review of the activity program calendar posted in the living room on 08/25/16 revealed: -The activity calendar was written on a dry erase board and dated August 2016. -The dates on the calendar did not correspond with the correct day of the week for August 2016. -For example, August 1st was noted to be on a Friday on the activity calendar but August 1st was actually on a Monday. -The dates on the August 2016 calendar actually corresponded with dates for July 2016 as July 1st was on a Friday. -The month on the dry erase board had been changed to August but the days of the week had not been changed to match. -Activities listed on the August 2016 calendar included: coloring, puzzles, dance, read, checkers, television, church, sing, newspaper, and bingo. -Activities were scheduled to last for 1 hour but some activities listed did not have a scheduled time period. -The activities were either scheduled for 1:00 p.m. - 2:00 p.m. or 7:00 p.m. - 8:00 p.m. Confidential interview with a resident revealed they do not do any activities at the facility. Confidential interview with a second resident revealed: -The resident spent most of the time sitting on the porch or listening to television. -The resident would occasionally play bingo. -When the resident wanted to play bingo he would have to ask staff and they would play with the resident. Confidential interview with a third resident	C 288		

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C 288	Continued From page 9 revealed: -The resident spent most of the day watching television. -The resident occasionally played bingo. Interview with the live-in staff on duty on 08/25/16 at 10:02 a.m. revealed: -The live-in staff person was responsible for doing the activities. -The Supervisor usually did the activity calendar. -There was one resident who liked to play bingo. Observation on 08/25/16 from 9:45 a.m. - 2:50 p.m. revealed no activities had been done or offered to the residents. Interview with the live-in staff on duty on 08/25/16 at 2:50 p.m. revealed: -She was not sure why the dates on the August 2016 activity calendar did not correspond with the correct days of the week. -She usually used the day of the week to go by when doing activities. -She had not noticed the dates and days of the week for August did not match. -The Supervisor usually did the activity calendar. -She usually did activities after she cleaned up from lunch. -She was probably going to do bingo today. Observation on 08/25/16 at 2:55 p.m. revealed: -After the live-in staff was asked about activities, she got a bingo game and went into the kitchen to the dining room table. -She got one resident from his room and they went into the dining room to play bingo. -The other residents either stayed in their rooms, watched television, or went outside to sit or smoke on the porch.	C 288		

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C 288	Continued From page 10 Interview with the Supervisor on 08/25/16 at 3:30 p.m. revealed: -A personal care aide (PCA) usually did the activity calendar each month. -The PCA was responsible for bathing the residents in the 3 facilities on the premises. -Activities were supposed to be scheduled for 10:00 a.m. and 2:00 p.m. -The PCA usually did the morning activities because she usually got off work at 1:00 p.m. -The live-in staff on duty was responsible for the 2:00 p.m. activities. -The Supervisor was not aware the August 2016 activity calendar still had the dates for July 2016 listed. -The Supervisor was not aware the activities were scheduled at 1:00 p.m. and 7:00 p.m. Interview with a personal care aide (PCA) on 08/25/16 at 5:30 p.m. revealed: -She worked from 8:00 a.m. - 1:00 p.m. daily and her job duties included assisting residents with bathing, dressing and grooming. -She rotated between 3 facilities on the premises providing personal care for residents. -She also volunteered to do activities once she completed all personal care duties. -She spent about 1 and ½ hours per day doing activities, but activities was not a part of her job responsibility. -She did not do activities in the facility every day. -She may go to each facility 1 or 2 days per week for about 1 and ½ hours each of those days to do activities with the residents. -Activities such as bingo, games or movie were done during this time. -Most of the games and supplies for activities were kept in a different facility on the premises. -She would help sometimes by changing the activity calendar each month, which was a dry	C 288		

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C 288	Continued From page 11 erase board. -When she changed the board she would change the month and dates, but she did not change the actual activities written in on each day. -She did not the current August 2016 calendar that was currently written on the dry erase board.	C 288		
C 330	10A NCAC 13G .1004(a) Medication Administration 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: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 2 of 2 residents (#1, #2) observed during the 12:00 noon medication pass on 08/25/16 including medications used to treat stomach motility, acid reflux, and / or stomach ulcers and a medication used to treat high phosphorus levels in those receiving dialysis. The findings are: 1. Review of Resident #1's current FL-2 dated 10/08/15 revealed the resident's diagnoses included stage 5 kidney disease (on dialysis), diabetes, hypertension, blindness, history of right above knee amputation, peripheral neuropathy, hyperlipidemia, and chronic pain.	C 330		

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C 330	Continued From page 12 Review of a physician's orders for Resident #1 revealed: -There was an order dated 10/29/15 for Reglan 10mg 4 times a day 30 minutes before meals and at bedtime. (Reglan increases the motility of the stomach to speed up the emptying of food from the stomach to help prevent problems with digestion and acid reflux.) -There was an order dated 08/09/16 for Renagel 800mg 2 tablets 3 times a day with each meal. (Renagel is a phosphate binder used to lower phosphorus levels in those receiving dialysis. Renagel exerts its effects on food by binding to the phosphorus in the foods eaten to prevent the body form absorbing too much phosphorus.) Review of the August 2016 medication administration record (MAR) revealed: -There was an entry for Reglan 10mg 4 times a day before meals and at bedtime. -Reglan was scheduled to be administered at 8:00 a.m., 12:00 p.m., 5:00 p.m., and 8:00 p.m. -There was an entry for Renagel 800mg take 2 tablets with each meal 3 times a day. -Renagel was scheduled to be administered at 8:00 a.m., 12:00 noon, and 5:00 p.m. Observation on 08/25/16 revealed: -The lunch meal was served to residents at 12:02 p.m. -Resident #1 refused to eat. Observation of the 12:00 noon medication pass on 08/25/16 revealed: -Resident #1 told the medication aide (MA) he did not eat lunch and he did not want to eat any lunch. -The MA continued with the administration of medications to Resident #1.	C 330		

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C 330	Continued From page 13 -The MA administered Reglan and Renagel to Resident #1 even though the resident had not eaten lunch and did not plan to eat any lunch. Interview with the medication aide (MA) on 08/25/16 at 2:00 p.m. revealed: -She usually administered medications to all residents in the three facilities on the premises. -She tried to get to this facility before the residents ate lunch but sometimes it was after they had eaten because the MA was giving medications in another facility. -She was aware Resident #1 did not eat lunch today. -Resident #1 would sometimes skip lunch but she still administered his medications. -She had not thought about whether the medications ordered before meals or with meals should be administered if the resident did not eat a meal. -She would notify the primary care provider. Interview with Resident #1 on 08/25/16 at 4:42 p.m. revealed: -He usually got his medications about the same time every day. -Sometimes he skipped eating lunch. -If he ate breakfast, he would usually skip lunch. -He did not eat lunch today. -He got his medications on an empty stomach today. -He denied any side effects from the medications. Attempt to contact Resident #1's primary care provider on 08/25/16 was unsuccessful. 2. Review of Resident #2's current FL-2 dated 02/16/16 revealed: -The resident's diagnoses included gastroesophageal reflux disease, mesenteric	C 330		

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	FCL078098	A. BUILDING: _____ B. WING _____	08/25/2016

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C 330	Continued From page 14 vascular insufficiency, chronic kidney disease, hypertension, coronary artery disease, anemia, chronic obstructive pulmonary disease, and hypercholesterolemia. -There was an order for Sucralfate 1 gram before meals and at bedtime. (Sucralfate coats the stomach to treat and prevent stomach ulcers and acid reflux.) Review of the August 2016 medication administration record (MAR) revealed: -There was an entry for Sucralfate 1 gram take 1 tablet 30 minutes before meals and at bedtime. -Sucralfate was scheduled to be administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Observation on 08/25/16 revealed: -The lunch meal was served to residents at 12:02 p.m. -Resident #2 finished eating his lunch at 12:25 p.m. and went outside to sit on the porch. Observation of the 12:00 noon medication pass on 08/25/16 revealed: -Resident #2 was administered Sucralfate 1 gram at 12:27 p.m. -Sucralfate was administered after the meal instead of before the meal as ordered. Interview with the medication aide (MA) on 08/25/16 at 2:00 p.m. revealed: -She usually administered medications to all residents in the three facilities on the premises. -She tried to get to this facility before the residents ate lunch but sometimes it was after they had eaten because the MA was giving medications in another facility. -She was aware Resident #2's Sucralfate was supposed to be administered before his meals.	C 330		

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C 330	Continued From page 15 Interview with Resident #2 on 08/25/16 at 5:00 p.m. revealed: -He usually got his morning medications before he ate breakfast. -He got his lunch time medications sometimes before he ate lunch and sometimes after he ate lunch. -He denied any current stomach problems.	C 330		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to	C 335		

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C 335	Continued From page 16 Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 2 of 2 residents (#1, #2) observed during the 12:00 noon medication pass on 08/25/16. The findings are: Observation and interview with the medication aide (MA) in the medication room on 08/25/16 at 12:25 p.m. revealed: -The MA took out 2 white medication soufflé cups and put them on top of the medication cart. -She put 5 different oral medications in a cup and stated they were for Resident #1. -She then put 1 oral medication in a cup and stated it was for Resident #2. -She did not label the cups with the resident's name, name of medications, or time of administration. -She did not cover or seal the cups. -She stacked the cups on top of each other and walked out of the medication room to find the residents and administer the medications. A. Review of Resident #2's current FL-2 dated 02/16/16 revealed: -The resident's diagnoses included	C 335		

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C 335	Continued From page 17	C 335		

gastroesophageal reflux disease, mesenteric vascular insufficiency, chronic kidney disease, hypertension, coronary artery disease, anemia, chronic obstructive pulmonary disease, and hypercholesterolemia.
-There was an order for Sucralfate 1 gram before meals and at bedtime. (Sucralfate coats the stomach to treat and prevent stomach ulcers and acid reflux.)

Observation on 08/25/16 during the 12:00 noon medication pass revealed:
-Immediately after preparing medications for Resident #1 and Resident #2, the medication aide (MA) took both unlabeled medication cups out of the medication room to look for the residents.
-The MA found Resident #2 on the porch, handed him the unlabeled cup with 1 oral medication and the resident took the medication at 12:27 p.m.
-The MA then went back into the facility to administer medications to Resident #1.

Refer to interview with the medication aide on 08/25/16 at 2:00 p.m.

Refer to interview with the Supervisor on 08/25/16 at 3:15 p.m.

B. Review of Resident #1's current FL-2 dated 10/08/15 revealed:
-The resident's diagnoses included stage 5 kidney disease (on dialysis), diabetes, hypertension, blindness, history of right above knee amputation, peripheral neuropathy, hyperlipidemia, and chronic pain.
-There was an order for Clonazepam 0.5mg 3 times daily. (Clonazepam is a controlled substance for anxiety.)
-There was an order for Oxycodone 15mg 4

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C 335	Continued From page 18 times daily. (Oxycodone is a controlled substance for moderate to severe pain.) Review of physician's orders for Resident #1 revealed: -There was an order dated 10/29/15 for Reglan 10mg 4 times a day 30 minutes before meals and at bedtime. (Reglan increases the motility of the stomach to speed up the emptying of food from the stomach to help prevent problems with digestion and acid reflux.) -There was an order dated 08/09/16 for Renagel 800mg 2 tablets 3 times a day with each meal. (Renagel is a phosphate binder used to lower phosphorus levels in those receiving dialysis.) -There was an order dated 06/03/16 for Lyrica 50mg 3 times daily. (Lyrica is a controlled substance used to treat nerve pain or seizures.) Observation on 08/25/16 during the 12:00 noon medication pass revealed: -Immediately after administering medication to Resident #2 on the porch, the MA administered medications to Resident #1 prior to returning to the medication cart and without the use of the MAR. -The MA administered the 5 oral medications to Resident #1 at 12:30 p.m. from the unlabeled cup. -The MA then returned to the cart and got Resident #1's insulin and glucometer to check his blood sugar. Refer to interview with the medication aide on 08/25/16 at 2:00 p.m. Refer to interview with the Supervisor on 08/25/16 at 3:15 p.m. _____	C 335		

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C 335	Continued From page 19 Interview with the medication aide (MA) on 08/25/16 at 2:00 p.m. revealed: -She was aware she was not supposed to prepare medications in advance (prepour). -She only prepoured medications because the residents would not come to the medication room. -It was easier to prepare the medications at one time instead of going back and forth to the medication cart. -She was not aware the prepoured medications were supposed to be labeled or covered. Interview with the Supervisor on 08/25/16 at 3:15 p.m. revealed: -The facility's policy was no prepouring was allowed. -The MAs know they are not supposed to prepour any medications. -She was not aware staff was prepouring medications.	C 335		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by:	C 341		

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C 341	Continued From page 20 Based on observations, interviews, and record reviews, the facility failed to assure staff documented the administration of medications immediately following administration and observation of 2 of 2 residents (#1, #2) actually taking their medications during the 12:00 noon medication pass on 08/25/16. The findings are: Observation and interview with the medication aide (MA) in the medication room on 08/25/16 at 12:25 p.m. revealed: -The MA took out 2 white medication soufflé cups and put them on top of the medication cart. -She put 5 different oral medications in a cup and stated they were for Resident #1. -She then put 1 oral medication in a cup and stated it was for Resident #2. -The MA precharted the administration of the medications for Resident #1 and #2 as she prepared the medications at 12:25 p.m. -The MA administered the medication to Resident #2 at 12:27 p.m. and to Resident #1 at 12:30 p.m. Interview with the medication aide (MA) on 08/25/16 at 2:00 p.m. revealed: -She had always initialed the medication administration records (MARs) as she was preparing the medications. -She was not aware she was supposed to document the administration of the medications after she actually observed each resident take their medications. Interview with the Supervisor on 08/25/16 at 5:45 p.m. revealed: -The facility's policy was no precharting was allowed. -The MAs had been trained to observe the	C 341		

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C 341	Continued From page 21 residents take the medications prior to documenting on the MARs.	C 341		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide mandatory annual infection prevention training for 2 of 3 medication aides (B, D) sampled that had been employed for more than one year. The findings are: 1. Review of Staff B's personnel file revealed: -Staff B was hired on 05/03/12. -Staff B was hired as live-in supervisor-in-charge and medication aide. -Staff B completed the Medication Aide Clinical	C 934		

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C 934	Continued From page 22 Skills checklist on 06/11/12. -Staff B passed the written Medication Aide Exam on 08/12/13. -The annual state approved infection control training was completed on 04/22/14 and 08/19/15. -There was no documentation the annual state infection control training had been completed since 08/19/15. Observation of Staff B on 08/25/16 at 12:25 p.m. revealed she was administering medications to residents in the facility. Interview with Staff B on 08/25/16 at 12:30 p.m. revealed: -She was working as a medication aide at the facility today on 08/25/16. -She recalled having infection control training in the past but she could not recall when or how often. Refer to interview with the Supervisor on 08/25/16 at 5:45 p.m. 2. Review of Staff D's personnel file revealed: -Staff D was hired on 01/12/06. -Staff D was hired as a supervisor and medication aide. -Staff D completed the Medication Aide Clinical Skills checklist on 12/20/05. -Staff D passed the written Medication Aide Exam on 03/01/06. -The annual state approved infection control training was completed on 08/19/15. -There was no documentation the annual state infection control training had been completed since 08/19/15. Interview with the Supervisor on 08/25/16 at 5:45	C 934		

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C 934	Continued From page 23 p.m. revealed: -She mostly worked as the Supervisor for all of the facilities on the premises. -She occasionally filled in as a medication aide and administered medications to the residents. -She had not taken the state approved infection control course since 08/19/15. Refer to interview with the Supervisor on 08/25/16 at 5:45 p.m. _____ Interview with the Supervisor on 08/25/16 at 5:45 p.m. revealed: -The Administrator was at an appointment and unable to be at the facility today. -The Administrator and the Supervisor were responsible for the personnel files. -The Supervisor was not aware the state approved infection control training was required annually. -She would get the training set up to be done as soon as possible.	C 934		
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 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	C935		

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C935	Continued From page 24 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: Based on interviews and record reviews, the facility failed to assure 1 of 3 medication aides (C) who administered medications in the facility had completed the 5 hour and 10 hour or the 15 hour state approved medication administration courses as required. The findings are:	C935		

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C935	Continued From page 25 Review of Staff C's personnel file revealed: -Staff C was hired on 03/18/16. -Staff C was hired as resident care / nursing assistant, medication aide, and live-in staff. -Staff C completed the Medication Aide Clinical Skills checklist on 03/18/16. -Staff C passed the written Medication Aide Exam on 07/13/15. -There was a medication aide verification form indicating Staff C's qualifying date of working as a medication aide at another assisted living facility was 03/15/16. -There was no documentation on the verification form of Staff C working as a medication aide prior to 03/15/16. -There was no documentation of Staff C completing the 5 hour, 10 hour, or 15 hour state approved medication aide training courses. Review of the March 2016 medication administration records (MARs) - August 2016 MARs revealed Staff C had administered medications each month from 03/2016 - 08/2016. Interview with a medication aide on duty on 08/25/16 revealed Staff C was another medication aide who worked at the facility but Staff C was not working today. Staff C was unavailable for interview on 08/25/16. Interview with the Supervisor on 08/25/16 at 5:45 p.m. revealed: -The Administrator was at an appointment and unable to be at the facility today. -The Administrator and the Supervisor were responsible for the personnel files. -The Supervisor was not aware Staff C was required to take the 5 hour, 10 hour, or 15 hour state approved medication aide training course	C935		

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C935	Continued From page 26 since he passed the written exam after 10/01/13. -She would let the Administrator know that Staff C would need to complete the training.	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 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	C992		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 7	2133 PRESTON ROAD MAXTON, NC 28364

(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
C992	Continued From page 27 and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure examination and screening for the presence of controlled substances were performed for 1 of 2 staff (A) sampled that was hired after 10/01/13. The findings are: Review of Staff A's personnel file revealed: -Staff A was rehired on 03/05/14. -Staff A was rehired as supervisor-in-charge (SIC), medication aide, and live-in staff. -There was no documentation of a controlled substance examination and screening for Staff A. Interviews with Staff A on 08/25/16 at 10:02 a.m. and 5:50 p.m. revealed: -She was rehired to work at the facility in March 2014. -She usually worked as live-in SIC. -She came in on Mondays at 3:00 p.m. and worked until 3:00 p.m. on Sundays. -She would then rotate and come back to work on Wednesdays at 3:00 p.m. and get off on Fridays at 3:00 p.m. -She did not have a urine drug screen test when she was rehired to work at the facility. -She was not aware she was required to have a urine drug screening. Interview with the Supervisor on 08/25/16 at 5:45 p.m. revealed: -The Administrator was at an appointment and unable to be at the facility today.	C992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078098	A. BUILDING: _____ B. WING _____	08/25/2016

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C992	Continued From page 28 -The Administrator was responsible for doing the urine drug screenings for staff. - Staff A had worked at the facility previously and then was rehired in March 2014. -The Supervisor did not know if a urine drug screening had been completed for Staff A. -She would contact the Administrator regarding Staff A's urine drug screening. No further information regarding a urine drug screening for Staff A was provided by the end of the survey on 08/25/16.	C992		