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	FCL017022	A. BUILDING: _____ B. WING _____	09/20/2018

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 20, 2018.	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 the walls, ceilings and floors were kept clean and in good repair in the living room, kitchen, bathroom, and resident bedroom doors. The findings are: Observation of the kitchen on 09/20/18 at 9:45am revealed: -There was an area approximately 8-feet by 4-inches on the front edge of the countertop that was missing, exposing the wood. -There was a crack in the linoleum flooring approximately 8-inches in length; the linoleum flooring was raised on each side of the hole. Observation of the bathroom to the left of the facility's front entrance on 09/20/18 at 9:57am revealed: -There was a hole in the linoleum flooring approximately 6-inches by 4-inches exposing the wood flooring. -The caulking around the bathtub was stained	C 074		

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C 074	Continued From page 1	C 074		

with black mildew.
-There were two areas on the wall behind the sink that had been patched, but had not been painted.
-The toilet paper holder had been installed with the opening turned to the outside of the fixture, prohibiting the holder to be inserted into the fixture that would hold the toilet paper in place.

Observation of the living room ceiling on 09/20/18 at 10:00am revealed the ceiling had cracked plaster that extended from the hallway into the living room that was approximately 8-feet in length by 2-inches wide.

Observation of the doors to the right of the facility entrance on 09/20/18 at 10:01am revealed:
-There were three doors that had holes patched; the patched areas had exposed holes and had not been sanded or painted.
-The paint was worn away around the door handles and the edge of the doors exposing wood; the doors had multiple areas that were discolored.

Observation of the hallway to the left of the facility entrance on 09/20/18 at 10:33am revealed three bedroom doors with worn paint, leaving the doors discolored.

Interview with a Supervisor-in-charge (SIC) on 09/20/18 at 10:22am revealed:
-He cleaned every day; he washed the doors at least once a week.
-The maintenance person had patched the doors but had not finished the repairs; he could not recall when the doors had been patched.
-He knew the toilet paper dispenser was installed incorrectly, and the spool could not be used to hold the toilet paper in place because the holder was turned in the wrong direction.

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C 074	Continued From page 2 -The maintenance person had installed the toilet paper dispenser backward several months ago (he did not recall the date); he had tried to take it off to fix it, but had not been able to get it loose. -He had noticed the caulking was stained; he had tried to clean it with bleach, but the stain would not come off. -He had noticed the damaged linoleum; it was supposed to be replaced, but the maintenance person had not finished; he did not know when the maintenance person was scheduled to return. -He had noticed the linoleum was split in the kitchen; he did not recall how long it had been split. -The maintenance person had started a lot of repairs but had not been back to finish. Interview with a second SIC on 09/20/18 at 10:40am revealed: -She had noticed the hole in the linoleum; it has been like that for several months. -The maintenance person was supposed to replace the floor in both residents' bathrooms but had only finished one of the two resident bathrooms. -The doors had been patched but had not been painted; she did not recall when the doors had been patched. -She had noticed the doors were discolored; the doors were discolored because they had been cleaned so much the paint had worn off. -She had not noticed the plaster was peeling from the ceiling. -The maintenance person was supposed to return to the facility to finish the repairs; she did not know when he was supposed to return because it was hard to reach the landlord. Interview with the Administrator on 09/20/18 at 12:53pm revealed:	C 074		

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C 074	Continued From page 3 -She was responsible for the furnishings in the facility and routine cleaning. -The landlord was responsible for repairs and maintenance, including doors, walls, windows, and carpet, everything except furnishings. -She had noticed the caulking in the bathroom needed to be replaced; she discussed this with the landlord (she did not recall the date). -She knew the toilet paper roll was not on the fixture because the maintenance person had installed it incorrectly. -The doors had been patched, she thought it was last year, but the maintenance person had never returned to finish the repairs. -She had noticed the cracked plaster on the ceiling; part of it had been repaired, but there was still an area that needed to be fixed. -She knew the kitchen cabinets needed to be repaired; the maintenance person had measured the missing counter top but had never returned to replace the missing countertop. -She knew there was a split in the kitchen linoleum; she did not recall how long it had been split. -The home was showing a lot of age and things needed to be repaired; they had been in the facility since 1993. -She had attempted to call the landlord multiple times, but he never returned her call until today (09/20/18). -The landlord was sending out a maintenance person to work on repairs needed in the home the week of 09/24/18). Telephone interview with the landlord on 09/20/18 at 2:27pm revealed: -He was responsible for the building, including maintaining the facility. -He was sending out a maintenance person next week (the week of 09/24/18).	C 074		

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C 074	Continued From page 4 -The interior was a gray area, but he tried to do a lot of the repairs. -He did not recall having a maintenance person patch the doors; sometimes for things that are wear and tear, the facility would take care of it. -He was not aware the linoleum needed to be repaired; he would have it looked at by the maintenance person. -He was not aware the kitchen countertop needed to be repaired; he would have it looked at by the maintenance person. -He was not aware the plaster on the ceiling was cracking; he would have it looked at by the maintenance person. -He had talked to the Administrator several times about repairs that needed to be done, including cutting trees back and pressure washing; he could not recall any other maintenance needs that were discussed or when he last talked to the Administrator.	C 074		
C 112	10A NCAC 13G .0318(a) Outside Premises 10A NCAC 13G .0318 Outside Premises (a) The outside grounds of new and existing family care homes shall be maintained in a clean and safe condition. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure the outside rear cement deck metal railing was kept in safe condition. The findings are: Observations of the rear cement deck on 09/20/18 at 10:29 am revealed: -There was a black metal railing around the	C 112		

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cement deck.
-The black metal railing was broken at the left corner of the cement deck.
-The black metal railing was attached to the brick façade of the house with metal screws and the metal screws were loosened.
-The black metal railing moved back and forth with hand movement.
-There were five chairs on the cement deck with their backs toward the loosened black metal railing.

Interview with a resident on 09/20/18 at 9:40 am revealed:
-The residents used the rear cement deck sometimes.
-One of the residents picked up nuts in the backyard and used the cement deck to reach the backyard.

Interview with another resident on 09/20/18 at 3:10 pm revealed:
-The cement deck was used by some of the residents.
-The black metal railing has been loose since 2017.
-One of the residents used the cement deck to access the backyard to pick up nuts.
-Other residents used the cement deck to hang clothes to dry.
-The cement deck was not used often, but she did not recall the last time she used the cement deck.

Interview with the Administrator on 09/20/18 at 10:20 am revealed:
-The landlord was responsible for maintaining the outer structure of the facility.
-The black metal railing had been damaged for a while, since 2017.

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C 112	Continued From page 6 -The damage to the black metal railing was caused by a dolly loaded with an appliance rolling back on to the railing. -The damaged railing was reported to the landlord twice before 09/20/18. -She had difficulty contacting the landlord and often left messages concerning needed repairs. -She attempted to explain to the landlord the need for the repairs both inside and outside of the facility. -She planned to call the landlord to request the repair of the black metal railing on the cement deck. Interview with the landlord on 09/20/18 at 2:25 pm revealed: -He was contacted by the Administrator of the facility on 09/20/18 concerning repairing the black metal railing. -He did not recall being contacted previously about the black metal railing but it was possible. -He was told that the railing was damaged by the hurricane. -He had contacted a maintenance person to repair the black metal railing next week, 09/24/18.	C 112		
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.	C 341		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure the Medication Administration Records (MARs) were accurate to include the initials of the Medication Aide (MA) who administered the medication for 3 of 3 sampled residents (#1, #2 and #3).

The findings are:

1. Review of Resident #1's current FL-2 dated 09/11/18 revealed:
-Diagnoses included schizophrenia, hypertension, non-insulin dependent diabetes mellitus, chronic obstructive pulmonary disease, vitamin D deficiency, hypoxemia and hypertriglyceridemia.
-There was an order for Losartan Potassium 25 milligrams (mg) daily. (Losartan Potassium is used to treat high blood pressure.)
-There was an order for Amlodipine 10 mg daily (Amlodipine is used to lower high blood pressure).
-There was an order for Vitamin D 2000 units daily (Vitamin D is a dietary supplement).
-There was an order for Aspirin 81mg nightly (Aspirin is a blood thinner used to prevent heart attacks.).
-There was an order for Paliperidone ER 6 mg daily at bedtime (Paliperidone ER is an anti-psychotic medication.).
-There was an order for Gemfibrozil 600 mg daily at bedtime (Gemfibrozil is used to treat high cholesterol.).
-There was an order for Symbicort 80-4.5 mcg two puffs daily (Symbicort is used to treat COPD.).
-There was an order for Latanoprost 0.005%

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instill 1 drop in each eye at bedtime (Latanoprost eye drops are used to treat glaucoma.).
-There was an order for Spiriva 18mcg inhale 1-capsule daily (Spiriva is used to prevent bronchospasm caused by COPD and reduce flare-ups of serious symptoms.).

Review of the July 2018, August 2018 and September 2018 Medication Administration Records (MARs) for Resident #1 revealed the only staff initials documented when medications were administered were the Administrator.

Interview with Resident #1 on 09/20/18 at 11:42am revealed her medications were administered by two different named Medication Aides (MA); she could not recall when the Administrator last administered her medications.

Refer to interview with a MA on 09/20/18 at 3:30 pm.

Refer to interview with a second MA on 09/20/18 at 3:56 pm.

Refer to interview with the Administrator on 09/20/18 at 3:45 pm.

2. Review of Resident #2's current FL-2 dated 06/28/18 revealed:
-Diagnoses included seizure disorder, mental retardation, malignant hyperthermia, and colitis.
-There was an order for multi-vitamin one tablet daily (used to treat vitamin deficiency) .
-There was an order for mesalamine Dr 1.2 gm three tablets daily (used to treat colitis).
-There was an order for Lisinopril 10 mg one tablet daily (used to treat hypertension) .
-There was an order for risperidone 2 mg one

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tablet in the morning (used to treat the irritability caused by autism, psychosis, schizophrenia, and bipolar disorder).
-There was an order for clonazepam 0.5 mg one tablet twice daily (used to treat seizures) .
-There was an order for calcium carbonate 500 mg one tablet twice daily (used to treat calcium deficiency) .
-There was an order for oxcarbazepine 300 mg one tablet twice daily (used to treat seizures).
-There was an order for oxybutynin CL ER 10 mg one tablet twice daily (used to treat overactive bladder).
-There was an order for sucralfate 1 gm one tablet three times daily (used to treat acid reflux and gastritis).
-There was an order for creon DR 36,000 units two capsules three times daily with meals and one capsule with a snack (used to treat protein enzyme deficiency).
-There was an order for trazodone 50 mg one tablet at bedtime (used to treat depression).
-There was an order for risperidone 4 mg one tablet at bedtime.
-There was an order for anti-diarrheal 2 mg two tablets with onset of diarrhea and one tablet with subsequent loose bowel movements (used to treat diarrhea).

Review of July 2018, August 2018, and September 2018 MARs for Resident #2 revealed the only staff initials documented when medications were administered were the Administrator.

Based on observations, record reviews, and interviews it was determined Resident #2 was not interviewable.

Refer to interview with a MA on 09/20/18 at 3:30

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C 341	Continued From page 10 pm. Refer to interview with a second MA on 09/20/18 at 3:56 pm. Refer to interview with the Administrator on 09/20/18 at 3:45 pm. 3. Review of Resident #3's current FL-2 dated 11/30/17 revealed: -Diagnoses included schizophrenia, dysfunctional uterus, obesity, hypertension, and allergies. -There was an order for therems-M one tablet daily (used to treat vitamin deficiency). -There was an order for lisinopril 20 mg one tablet daily (used to treat hypertension). -There was an order for hydrochlorothiazide 50 mg one tablet daily (used to treat hypertension). -There was an order for cetirizine HCL 10 mg one tablet daily (used to treat allergies) . -There was an order for calcium 600 + D3 one tablet twice daily (used to treat calcium and vitamin D3 deficiency). -There was an order for fluticasone prop 50 mcg inhale one spray into each nostril twice daily (used to treat allergies). -There was an order for risperidone 0.5 mg one tablet at bedtime (used to treat schizophrenia). -There was an order for ibuprofen 600 mg one table every six hours as needed (used to treat inflammation). -There was an order for medrozyprogesterone 150 mg inject intramuscularly one milliliter every three months (used to treat endometriosis). -There was an order for sudogest 30 mg one tablet daily (used to treat seasonal allergies). -There was an order for hydrocortisone 1% apply as directed to affected area three times daily as needed (used to treat dermatitis).	C 341		

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C 341	Continued From page 11 Review of July 2018, August 2018, and September 2018 MARs for Resident #3 revealed the only staff initials documented when medications were administered were the Administrator. Interview with Resident #3 on 09/20/18 at 9:40 am revealed: -The staff administered medications to her. -The Administrator gave her medications to her most of the time. Refer to interview with a MA on 09/20/18 at 3:30 pm. Refer to interview with a second MA on 09/20/18 at 3:56 pm. Interview with a MA on 09/20/18 at 3:30pm revealed: -When the MA administered medications she always checked the MAR, she checked to make sure it was the correct resident, dosage and time. -She documented administering the medication by initialing the MAR. -She administered medication on 09/20/18; she did not initial the MAR because the MAR was not at the facility. -She notified the Administrator after she had administered the medication and the Administrator signed off the MAR. -She had not initialed the MAR for any medications they had administered. Interview with a second MA on 09/20/18 at 3:56pm revealed: -He administered medications to the residents at the facility; he last administered medications "one-day last week." -Before he administered medications he made	C 341		

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sure he had the right medication, the right resident, the right time and the right dosage.
-He did not look at the MAR, but used the prescriptions from the pharmacy for directions for administering the medication.
-He notified the Administrator when he had administered all the residents ' medications, and she documented in the MAR.
-He had never documented on the MAR; he had been administering medications for 2-3 weeks.

Interview with the Administrator on 09/20/18 at 3:45 pm revealed:
-When another MA administers the medication, the medications were prepped by her and she gave the MA the medication cup to give to the resident.
-The other MAs did not administer medications, they only administered inhalers and performed fingersticks for the residents."
-Two people from other facilities told her the MAs, who had not taken the medication test, were not allowed to administer medications.
-The two MAs had completed the validation skills checklist, the medication aide training and the five hour or 10 hour training course.
-She and the Supervisor in Charge (SIC) were responsible for ensuring the MARs were accurate and medication administration was completed accurately.
-MAR audits were not done because she signed the MARs as the medications were administered.
-She did sign the MARs in place of the two MAs who administered the medications and inhalers to the residents.
-She did know that she was not supposed to sign the MARs if she did not administer the medication.

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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). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the medications administration records were accurate and complete for 1 of 3 sampled residents (#2) who was prescribed a daily multi-vitamin with none available to administer and documentation of administration by the facility staff. The findings are: Review of Resident #2's current FL-2 dated 06/28/18 revealed: -Diagnoses included seizure disorder, mental	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017022	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D & H FAMILY CARE HOME	1111 YARBOROUGH ROAD MILTON, NC 27305

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retardation, malignant hyperthermia, and colitis.
-There was an order for multi-vitamin (used to treat vitamin deficiency) one tablet daily.

Review of Resident #2's July 2018, August 2018 and September 2018 medication administration records (MAR) revealed:
-There was an entry for multi-vitamin one tablet daily, scheduled for 8:00 am.
-The initials of the Administrator were documented on the MARS indicating daily administration of the multi-vitamin.

Observation of Resident #2's medication on hand on 09/20/18 at 12:00 noon revealed the facility did not have any multi-vitamins for Resident #2 available for administration.

Based on observations, record reviews, and interviews, it was determined Resident #2 was not interviewable.

Interview with the facility's contract pharmacist on 09/20/18 at 12:50 pm revealed:
-The last order date for Resident #2's multi-vitamin was 11/17/15.
-The FL-2 dated 06/28/18 was not received.
-The last dispense date for Resident #2's multi-vitamin was 10/19/16.
-A request for refill was sent to Resident #2's medical provider on 09/26/16 and was denied by that medical provider.
-The multi-vitamin was still placed on Resident #2's MARs because the medication was not discontinued.

Interview with the facility's contract Nurse Practitioner (NP) on 09/20/18 at 3:05 pm revealed:
-She recalled ordering the multi-vitamins for

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C 342	Continued From page 15 Resident #2 in 2017. -She did not remember the reason for ordering multi-vitamins for Resident #2 but she thought the reason was for strength. -She was contacted by the facility on 09/20/18 requesting a new prescription. -She sent the prescription to the pharmacy electronically for Resident #2's multi-vitamins. -She did not know the medication had not been dispensed since 2016 by the pharmacy. Interview with the Administrator on 09/20/18 at 3:40 pm revealed: -Resident #2 received the last dose of multi-vitamins on 09/20/18 at 8:00 am. -She had thrown the empty container for the multi-vitamins away. -She did know that the pharmacy had not dispensed the multi-vitamin since 2016. -She was purchasing the multi-vitamins for Resident #2. -She did not have any receipts documenting the purchase of the multi-vitamins for Resident #2. -The pharmacy was not able to provide any documentation that she was purchasing multi-vitamins for Resident #2. -The last date that she purchased multi-vitamins for Resident #2 was 08/20/18. -The pharmacy sent a new bottle of multi-vitamins on 09/20/18 for Resident #2.	C 342		