PRINTED: 01/13/2020 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		FCL064034	B. WING		12/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
Δ HFΔRT	2 CARE FAMILY CARE H	IOME 307 N PINE	STREET			
ATILANI	2 OAKE PAINET OAKE II	SPRING HO	DPE, NC 2788	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 000	000 Initial Comments		C 000			
	The Adult Care Licensinitial survey on 12/17	sure Section conducted an 7/19.				
C 140	10A NCAC 13G .0409 Tuberculosis	5(a)(b) Test For	C 140			
	(a) Upon employment home, the administrative-in non-residents stuberculosis disease imeasures adopted by Services as specified including subsequent Copies of the rule are contacting the Depart Services. Tuberculosis Mail Service Center, I (b) There shall be do home that the administrany live-in non-reside	5 Test For Tuberculosis at or living in a family care tor, all other staff and any shall be tested for in compliance with control of the Commission for Health in 10A NCAC 41A .0205 amendments and editions. It is available at no charge by sment of Health and Human is Control Program, 1902 Raleigh, NC 27699-1902. Incumentation on file in the strator, all other staff and tents are free of tuberculosis direct threat to the health or				
	facility failed to assure	as evidenced by: ews and interviews, the e 1 of 3 sampled staff (Staff ire for Tuberculosis (TB)				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
			7. BOILDING		
		FCL064034	B. WING		12/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
A HEART	2 CARE FAMILY CARE H	IOME	E STREET	_	
			HOPE, NC 2788		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 140	Continued From page	e 1	C 140		
	The findings are:				
	reading as positive or completed on 11/29/0 sign of inflammatory of -There was no documupon hire. Interview with Staff A revealed: -The Administrator and -She had the results of departmentShe did not provide to of the TB skin test results.	ealed: /05/19. tation of a TB skin test n 11/15/05 and a chest X-ray 05 which showed no active disease. nentation of a TB skin test on 12/17/19 at 5:00 pm Iministered a TB test. read at the local health the Administrator with a copy sults.			
	12:57pm revealed: -Staff A had provided 11/15/05 and 11/29/0 -She administered a 12/12/19Staff A did not submiresultsStaff A was expected at the local health dep -Staff A was expected	5 results on 11/13/19. TB skin test to Staff A on t a copy of the TB skin test I to have the TB results read partment. I to submit her TB results.			
	test prior to hire.	nsible for providing a TB skin			

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-The Administrator was responsible for assuring all staff completed a TB test prior to hire.

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
				_	
		FCL064034	B. WING		12/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
		307 N PIN	E STREET		
A HEART	2 CARE FAMILY CARE H	HOME	OPE, NC 2788	2	
240.15	CLIMMADV CT		1		N 0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 147	10A NCAC 13G .0406 Qualifications	6(a)(7) Other Staff	C 147		
		_			
	This Rule is not met as evidenced by: TYPE B VIOLATION				
	Based on record reviews and interviews, the facility failed to assure 2 of 3 sampled staff, (Staff A and Staff B), had a statewide criminal background check completed upon hire.				
	The findings are:				
	Review of Staff A's, medication aide (MA) personnel record revealed: -Staff A was hired on 11/05/19. -There was no documentation of a signed consent for a criminal background check for Staff A.				
	revealed: -She had worked as a -Staff A had complete check last weekThe Administrator co state-wide search on -She did not know if t				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	1 ' '	SURVEY PLETED
			1			
		FCL064034	B. WING		12	/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
A HEART	2 CARE FAMILY CARE H	IOME	IE STREET	•		
	OLIMANA DV. OT		HOPE, NC 2788		OODDECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTII CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 147	Continued From page	e 3	C 147			
	check.					
	12:57pm revealed: -She thought the online search for Staff A courage -She knew a state with check was needed for a search for a state with a search for a state with a search for a criminal background of the search for a criminal background for a staff B was hired on the search for a criminal background for a crim	de criminal background r all staff upon hire. bund to completing the check last week." h Administrator on om. s, personal care aide (PCA) ealed: 11/16/19.				
	Interview with Staff B revealed:	on 12/17/19 at 5:09pm a PCA for two or three				
	weeksShe had not complet check.	ted a criminal background				
	-She had not been as background check.	sked to complete a criminal				
	12:57pm revealed: -She did not complete check for Staff B"I just had not gotten criminal background."					
	Refer to interview with	h Administrator on	1			

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DIVISION	or riealiti Service Negu	lialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
						
		F01.004004	B. WING		404	- /0040
		FCL064034			12/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
		307 N PI	NE STREET			
AHEARI	2 CARE FAMILY CARE H	SPRING	HOPE, NC 27882	2		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J I	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
C 147	Continued From page	e 4	C 147			
	12/17/19pm at 12։57ր	om.				
	Intonvious with the Adr	 ministrator on 12/17/19 at				
	12:57pm revealed:	าแแรแสเบเ บเา 12/17/19 สเ				
		e for maintaining personnel				
	records.	To maintaining personner				
		ackground checks were				
	required for the staff.	•				
		e for completing the state				
	wide criminal backgro	ound checks for all staff				
	upon to hire.					
		lity to assure 2 of 3 sampled				
	staff, (Staff A and Sta					
	_	check completed upon hire				
		e health, safety and welfare				
	of the residents and o	constitutes a Type B				
	Violation.					
	The facility provided a	n plan of protection in				
		. 131D-34 on 12/20/19 for				
	this violation.	. 1310-34 011 12/20/19 101				
	and violation.					
	CORRECTION DATE	FOR THE TYPE B				
		NOT EXCEED JANUARY 31,				
	2020.	·				
C 912	G.S. 131D-21(2) Dec	laration of Residents' Rights	C 912			
	G.S. 131D-21 Declar	ration of Resident's Rights				
		nave the following rights:				
	2. To receive care ar					
		e, and in compliance with				
	relevant federal and s	state laws and rules and				
	regulations.					
	This Rule is not met					
	Based on observation	ns, record reviews, and				

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		FCL064034	B. WING		12/	17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
		307 N PII	NE STREET			
AHEARI	2 CARE FAMILY CARE I	SPRING	HOPE, NC 27882	!		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 912	Continued From page	e 5	C 912			
	interviews, the facility received care and se appropriate, and in confederal and state law related to other staff of	r failed to ensure residents rvices which are adequate, compliance with relevant s and rules and regulations qualifications and Adult Care le training and competency				
	facility failed to assur A and Staff B), had a background check co	ompleted upon hire. [Refer to I3G .0406(a)(7) Other Staff				
	facility failed to assur aides (Staff A and Sta administering medica completed the medica competency validatio employee verification aide training. [Refer the	ations had taken and ation clinical skills in checklist, completed in or completed medication o Tag 935 G.S. Medication Aide; Training and				
C935	G.S. § 131D-4.5B (b) Aides;Training and C		C935			
	G.S. § 131D-4.5B (b) Medication Aides; Tra Evaluation Requirem	aining and Competency				
	home is prohibited from any unsupervised methat individual has promedication aide during	er 1, 2013, an adult care om allowing staff to perform edication aide duties unless eviously worked as a ng the previous 24 months in or successfully completed all				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		FCL064034	B. WING		12/	17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
A HEART	2 CARE FAMILY CARE H	HOME	NE STREET HOPE, NC 27882	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C935	Department that incluin all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monitor bleeding occurs or the exists. (2) A clinical skills evan NCAC 13F .0503 and (3) Within 60 days from individual must have a. An additional 10-hode developed by the Department of the exists. 2. The key principles administration. 2. The federal Center Prevention guidelines applicable, safe inject procedures for monitor bleeding occurs or the exists. b. An examination deby the Division of Head	g program developed by the ides training and instruction of medication rs for Disease Control and son infection control and, if tion practices and oring or testing in which ee potential for bleeding aluation consistent with 10A id 10A NCAC 13G .0503. In the date of hire, the completed the following: our training program partment that includes on in all of the following: of medication rs of Disease Control and so in infection control and, if	C935			
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
		and record reviews, the e 2 of 2 sampled medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		FCL064034	B. WING		12/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
A HEART	2 CARE FAMILY CARE H	IOME 307 N PINI			
			OPE, NC 2788		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
C935	Continued From page	e 7	C935		
		tions had taken and			
	The findings are:				
	personnel record reversity - Staff A was hired on - There was document the medication aide would - There was no document record was no document raining of 5 hours, 10 - There was no document raining of 5 hours, 10	11/05/19. tation Staff A had passed written exam on 10/13/09. mentation of MA employment previous 24 months. mentation of medication thours or 15 hours. mentation of a medication ency validation checklist. Ints' medication (MARs) for November and documented administration (17/19 and 11/24/19.			
		nts' MARs for December documented administration 01/19, 12/04/19 and			
	revealed: -Staff A administered -He could not remember the staff A had administered	ber the days and times hinistered medication to him. and resident on 12/17/19 at			

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Division of	of Health Service Regu	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		FCL064034	B. WING		12/1	7/2019
NAME 05 B	20,4250 02 01 02 150	OTDEET.	DDD500 0171/ 074	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ALE, ZIP CODE		
A HEADT	2 CARE FAMILY CARE H	307 N P	INE STREET			
AIIEANI	2 OAKETAMIET OAKET	SPRING	HOPE, NC 2788	2		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
C935	Cantinual Framero	- 0	C935			
0933	Continued From page	e o	0933			
	-He could not remem	ber the days and times				
		ninistered medication to him.				
	Interview with Staff A	on 12/17/19 at 5:00pm				
	revealed:	on 12/11/10 at 0.00pm				
	-She had been emplo	aved for two months				
	-She worked at least					
	-She had administere	•				
	residents since her er	· ·				
	-She had initialed on					
	administered medical					
	T	lication aide exam in 2009.				
		A with a previous employer.				
	-	nedication training hours				
	with a pervious emplo	oyer.				
	-She had completed	eight Continuing Education				
	Hours of medication t	training since her hire.				
	-She did not provide t	the Administrator with copies				
	of her previous medic	•				
	-	ted a medication clinical				
	skills competency val					
	Interview with the Adr	ministrator on 12/17/19 at				
	5:32pm revealed:	111111011111111111111111111111111111111				
	-Staff A administered	medications to the				
		medications to the				
	residents.					
		ad not requested verification				
		on aide employment for Staff				
	A.					
	=	least eight Continuing				
	Education Hours of m	nedication training since her				
	hire.					
	Refer to the interview	with the Administrator on				
	12/17/19 at 5:32pm.					
	2. Review of Staff B's	s, personal care aide (PCA)				
	personnel record reve					

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-Staff B was hired on 11/15/19.

-There was no documentation that Staff B passed

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SUR'		
AND FLAN	DF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		FCL064034	B. WING		12/17/2	2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
A HFART	2 CARE FAMILY CARE H	IOME 307 N PIN	E STREET			
7111271111		SPRING I	HOPE, NC 2788	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
C935	Continued From page	9	C935			
	the medication aide was no docum verification for the pre-There was no docum training of 5 hours, 10. There was no docum clinical skills competed Review of two resides 2019 revealed Staff A of medications on 11/11/22/19 and 11/25/11 Review of two resides 2019 revealed Staff A of medications on 12/11/22/19 revealed Staff A of medications on 12/11/22/19 and 11/25/11 Review of two resides 2019 revealed Staff A of medications on 12/11/22/19 and 12/11/22/19 revealed Staff A of medications on 12/11/22/19	vritten exam. nentation of employment evious 24 months. nentation of medication of hours or 15 hours. nentation of a medication ency validation checklist. nts' MARs for November of documented administration 11/19, 11/17/19, 11/19/19,				
	revealed Staff B admi	ent on 12/17/19 at 5:18pm inistered medications to him I his medications on the and the morning of 12/17/19.				
	5:22pm revealed Statemedications to him are	nd resident on 12/17/19 at if B administered nd had administered his vening of 12/16/19 and the				
	revealed: -She was employed figure -She worked from 8:0 to three days weeklyShe worked at least -She had administered residentsShe completed some	two to three days weekly.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING: _	A. BUILDING:		
		FCL064034	B. WING		12/	17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
A HEART	2 CARE FAMILY CARE H	IOME	NE STREET HOPE, NC 27882	2		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	IF CORRECTION	(75)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C935	Continued From page	e 10	C935			
	examShe did not provide a aide exam results to the	a copy of her medication he Administrator. ed a medication clinical				
	Interview with the Administrator on 12/17/19 at 5:32pm revealed: -Staff B administered medications to the residentsStaff B had not taken the written medication aide examStaff B provided documentation of three hours of medication training.					
	Refer to the interview 12/17/19 at 5:32pm.	with the Administrator on				
	Interview with the Administrator on 12/17/19 at 5:32pm revealed: -She was responsible for ensuring staff training was completedShe had not scheduled the medication clinical skills competency validation checklistShe was aware the medication clinical skills competency validation checklist needed to be completed by a Registered Nurse.					
	medication aides (Sta administering medical completed the medical competency validation employee verification aide training was detrained welfare or the restrype B Violation.	ation clinical skills n checklist, completed , or completed medication imental to the health, safety sidents and constitutes a				

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Division of	Division of Health Service Regulation					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL064034	B. WING		12/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
A HEART	2 CARE FAMILY CARE H	OME	E STREET IOPE, NC 2788	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C935	Continued From page	e 11	C935			
	this violation.					
	CORRECTION DATE VIOLATION SHALL N 2020.	FOR THE TYPE B IOT EXCEED JANUARY 31,				
C992	G.S. § 131D-45 G.S. and screening for	§ 131D-45. Examination	C992			
	_	mination and screening for olled substances required sloyment in adult care				
	licensed under this Ar conditioned on the ap examination and scre substances. The exam be conducted in acco Chapter 95 of the Gerprocedure that utilizes may be used for the example of applicants and may the results of the applicants of the applicant unless the adult care home wapplicant's prescribing controlled substance.	mination and screening shall rdance with Article 20 of heral Statutes. A screening is a single-use test device examination and screening is be administered on-site. If dicant's examination and expresence of a controlled care home shall not employ the applicant first provides to written verification from the grant physician that every				

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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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL064034	B. WING		12	2/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
A HEART	2 CARE FAMILY CARE H	IOME	INE STREET			
	I	SPRING	HOPE, NC 27882			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C992	Continued From page 12		C992			
	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: Based on record reviews and interviews, the facility failed to assure 2 of 3 staff sampled (Staff A and B) had an examination and screening for the presence of controlled substances completed upon hire. The findings are: 1. Review of Staff A, medication aide (MA) personnel record revealed: -Staff A was hired on 11/05/19There was no documentation Staff A completed a consent for a controlled substance examination and screening prior to hireThere was no documentation Staff A had completed a controlled substance examination and screening prior to hire.					
	revealed: -She had been emplorate and not complete examination and screen linterview with the Adria 12:57pm revealed, she with the screen screen and screen are sent are sent and screen are sent	ted a controlled substances sening upon hire. ministrator on 12/17/19 at the did not complete the				
	for Staff A upon hire.	examination and screening				
	Reter to the interview	with the Administrator on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		FCL064034	B. WING		12/17/2019					
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE						
A HEART 2 CARE FAMILY CARE HOME STREET										
	OUR MARK OF		OPE, NC 2788							
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	LD BE COMPLETE					
C992	Continued From page 13		C992							
	12/17/19 at 12:57pm.									
	2. Review of Staff B, personal care aide (PCA) personnel record revealed: -Staff B was hired on 11/15/19There was no documentation Staff B completed a consent for a controlled substance examination and screening prior to hireThere was no documentation Staff B had completed a controlled substance examination and screening prior to hire. Interview with Staff B on 12/17/19 at 5:09pm revealed: -She had worked for at least two to three weeksStaff B completed a controlled substance examination and screening at her Primary Care Physician on 12/12/19She did not obtain the screening resultsShe stated, "I haven't gone to pick it up."									
	controlled substance for Staff B upon hire.	ne did not complete the examination and screening								
Refer to the interview with the Administrator 12/17/19 at 12:57pm.										
	12:57pm revealed: -She was responsible records and ensuring substances examinating-She was aware of here.	s examination and screening								

Division of Health Service Regulation

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