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C 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow-up survey on 01/24/20.	C 000		
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 interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff C) had a criminal background check upon hire. Review of Staff A's employee record revealed: -Staff A was hired on 07/30/18 as a medication aide. -Staff A had no documentation of having a criminal background check completed upon hire or thereafter. -There was no documentation Staff A signed a consent for a criminal background check. Interview with the Resident Care Coordinator (RCC) on 01/24/20 at 1:55pm revealed: -Staff A worked in the facility for over a year. -She was sure Staff A probably had a background check completed upon hire, but she could not locate any record of it. -She had contacted the company that currently conducted background checks for staff, but they had no documentation of having completed a background check for Staff A on file.	C 147		

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C 147	Continued From page 1 -She was not aware of what company the facility had previously used to conduct background checks, so there was no way to contact the company to request documentation if a background check had previously been done. -She was responsible for requesting background checks for new hires prior to them working in the facility. Telephone interview with the Administrator on 01/24/20 at 3:45pm revealed: -He did not know there was no documentation in Staff A's record of a criminal background check being completed upon hire for Staff A. -The RCC was responsible for assuring all staffing requirements were met prior to staff working in the facility.	C 147		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement a physician orders for 1 of 3 sampled residents (Resident #1) related to monthly blood pressure checks and weights. The findings are:	C 249		

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C 249	Continued From page 2 Review of Resident #1's current FL-2, dated 8/14/19, revealed diagnoses included dementia, dysphagia, type 2 diabetes mellitus, polymyalgia rheumatica, and history of fracture of left femur. Review of Resident #1's record revealed: -There was an order dated 11/20/19 for weekly blood pressure checks. -There was an order dated 11/20/19 for weekly weight checks, with instructions to notify the physician of a weight gain of greater than 5 pounds. Review of Resident #1's November 2019 Medication Administration Records (MAR) revealed: -There was an entry documented "check vitals monthly". -There was no documentation of any vital signs during the month of November 2019. -There was an entry documented "check weight monthly', there were no documented entries. Review of Resident #1's December 2019 MAR revealed: -There was an entry documented "check vitals monthly". -There was no documentation of any vital signs during the month of December 2019. -There was an entry documented "check weight monthly", there were no documented entries. Review of Resident #1's January 2020 MAR revealed: -There was an entry documented "check vitals monthly". -There was no documentation of any vital signs from 01/01/20-01/21/20. -There was an entry documented "check weight	C 249		

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C 249	Continued From page 3	C 249		

monthly".
-There was no documentation of Resident #1's weight from 01/01/20-01/21/20.

Telephone interview with Resident #1's nurse practitioner on 01/24/20 at 12:25pm revealed:
-She thought Resident #1 had diastolic heart failure, which would be why she would have written an order for weekly blood pressure, heart rate, and weight checks.
-Resident #1's vital signs and weight were "relatively stable."
-She expected the facility to implement any orders she had written immediately, and to communicate with her "as soon as possible" if there were a reason an order could not be implemented.
-Not having his vitals and weight monitored closely on a weekly basis could have resulted in Resident #1 experiencing an unnoticed exacerbation of heart failure symptoms, which could be detrimental to his health.
-She had seen Resident #1 recently, but did not routinely weigh him during her assessments, so she was unsure if he might have had a weight gain of more than 5 pounds since the facility had not been weighing him regularly.

Interview with the Resident Care Coordinator (RCC) on 01/24/20 at 11:45am revealed:
-All residents were supposed to be weighed monthly by staff.
-She was not aware that Resident #1 had an order to have his blood pressure, pulse, and weight checked weekly.
-She had contacted the staff member who she thought usually checked vitals and weights for residents and the staff member had told her she documents any vitals she checks on the MAR.
-Sometimes the "house manager" sometimes put

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C 249	Continued From page 4 orders in the residents' records and did not tell her about the new orders, so she was not aware to add orders to the residents MARs. -She thought that was probably what had happened with Resident #1's order for weekly blood pressure, pulse and weight checks. Interview with a medication aide on 1/24/20 at 11:50 revealed: -He had not noticed any weight gain for Resident #1. -He was not aware Resident #1 had an order for weekly blood pressures, pulse, and weight checks. -Staff usually checked all residents ' weights and vitals monthly, by the 5th of the month, and staff shared this responsibility. Telephone interview with Administrator on 1/24/20 at 3:35pm revealed: -He was not aware that Resident #1 had an order from 11/20/19 for weekly blood pressures, pulse and weight checks. -When new orders were received from physicians, the staff member who received the new order were to notify the RCC and the place the order in the resident's record. -The RCC was responsible for transcribing new orders on the MAR.	C 249		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	C 284		

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C 284	Continued From page 5 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled resident (Resident #3) with physician's orders for nectar thickened liquids. The findings are: Review of Resident #3's current FL2 dated 12/30/19 revealed diagnoses included dementia and oropharyngeal dysphasia. Review of an electronically signed hospital discharge order for Resident #3 dated 10/31/19 revealed Resident #3 was to be served a "mechanically altered/chopped/ground diet with nectar thick liquids." Review of the therapeutic diet list located in the kitchen on 01/24/20 revealed Resident #3 was to be served a mechanical soft diet with thickened liquids (no consistency). Observation of the kitchen area on 1/24/20 at 9:28am revealed: -There was a packaged container of "instant food thickener" in the refrigerator used to prepare food and drinks to desired consistency. -There were instructions on the label of packaged container for preparing drinks of nectar thick consistency. -The instructions indicated to prepare a 4oz. drink include one pump required for nectar consistency, for a 8oz drink include two pumps for nectar consistency and stir for 30 seconds. Observation of the lunch meal on 01/24/20 from 12:35pm-1:30pm revealed:	C 284		

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C 284	Continued From page 6 -The medication aide (MA) served Resident #3 his meal and then proceeded to prepare his beverage. -The MA did not refer to the diet list and he did not read the instructions on the back of the instant food thickener prior to preparing the beverage. -The MA took two 6oz cups and poured water in one cup and lemonade in another cup and put one squirt of thickener in each cup. -The MA filled both cups to the rim and did not measure the amount of liquid poured. -The MA stirred both drinks and attempted to serve to Resident #3, both drinks were thin consistency. -The MA did not know the size of the cups used to prepare the beverage. -After prompting, upon observing the bottom of each cup, it was determined both glasses were 6oz. -After reviewing the instructions, the MA did not serve the drinks to Resident #3 and restarted preparation. -The MA followed the instructions on the container using 8oz of liquid and prepared the drinks to nectar consistency. -Resident #3 consumed his drinks without difficulty. Interview with the MA on 1/24/20 at 1:04pm revealed: -He prepared Resident #3's beverages without thickener. -He always used 6oz. cups and used one pump of thickener. -He did not realize he was not following the instructions. -He thought he prepared Resident #3's drinks properly. -He did not know what a nectar thickened	C 284		

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consistency drink resembled.
-He thought he was using an 8oz. cup and had not looked on the bottom of the cup.
-He was trained by another staff person to prepare nectar thickened liquids.
-He could not remember the last time he had been trained.

Interview with Resident #3's responsible party on 01/24/20 at 1:20pm revealed:
-Resident #3 was on a mechanical soft diet with thickened liquids.
-She was unsure how Resident #3's drinks were supposed to be prepared, but staff usually added some thickener in his drinks when she was in the facility for meals.
-She had observed Resident #3 to "choke" frequently on both his food and his drinks at the facility.

Interview with Resident #3's Nurse Practitioner (NP) on 01/24/20 at 12:25pm revealed:
-She recalled that Resident #3 was on a mechanical soft diet with thickened liquids.
-She did not know of the consistency of thickener ordered for him but had not changed his order for the level of thickener that was previously ordered for him.
- Resident #3 was at an increased risk for choking and she thought he had been sent out of a choking incident "a while ago."

Interview with the Resident Care Coordinator (RCC) on 01/24/20 at 1:15pm revealed:
-There was a measuring cup in the kitchen that should have been used to prepare thickened liquids.
-Staff were supposed to measure drinks properly and apply the thickener according to the instructions.

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C 284	Continued From page 8 -She did not know why residents Resident #3's drinks were not prepared properly. -All staff recently received training "a few months ago ". Telephone interview with the Administrator on 1/24/20 at 1:30pm revealed: -He expected residents to receive thickened liquids as ordered. -He expected staff to refer to instructions on the thickener. -All staff received training 3 months ago regarding preparing nectar thickened liquids. -Staff should be utilizing a measuring cup to measure liquid and add the correct amount of thickener. Based on observations, interviews, and record review Resident #3 was not interviewable.	C 284		
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 and interviews, the facility failed to implement an activity program that promoted active involvement for 4 of 4 sampled residents who resided in the facility. Review of the facility's activity calendar on 01/24/20 for January 2020 revealed: -The facility had a scheduled activity of bingo from 10am-11am and trivia from 3pm-4pm.	C 288		

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C 288	Continued From page 9 Observation of the facility on 01/24/20 from 9:30am and 4:00pm revealed: -No scheduled activities were completed as scheduled on the activity calendar. -No other organized activities occurred on 01/24/20 between 9:30am and 4:00pm. Interview with a medication aide on 01/24/20 at 1:43pm revealed: -He usually played trivia with the residents first thing in the morning and in the afternoon. -The facility did have an activity calendar, but staff did not always do the activity that was scheduled. -The residents did not play bingo today, as scheduled. -He did not realize bingo was scheduled for today. -He planned to play trivia with the residents in the afternoon, as scheduled. Interview with a resident's responsible party on 01/24/20 at 1:20pm revealed: -She visited the facility daily, usually arriving around 10:30am, and never observed any organized activities being carried out by staff with the residents. -She was concerned that her family member did not have any physical activity once up and in a wheelchair for the whole day. -She usually stayed at the facility through lunch, she would take her family member to his room and try to do some activities with him one-on-one, such as ball toss or stretching, to help him with circulation. -When she arrived at the facility, residents were usually in their rooms or sitting in the common area watching television. Interview with Resident Care Coordinator (RCC)	C 288		

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C 288	Continued From page 10 on 01/24/20 at 3:15pm revealed: -She was aware staff had not carried out the activities as scheduled today. -The staff member on duty was responsible for assuring activities were implemented as scheduled. -The facility contracted with an activity director to create their activity program for the residents, for a minimum of 14 hours per week. Telephone interview with the Administrator on 01/24/20 at 3:45pm revealed: -He was not aware that activities were not implemented as scheduled today. -He expected staff member on duty would assure activities occurred as scheduled on the calendar, for a minimum of 14 hours per week.	C 288		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide	C 453		

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C 453	Continued From page 11 safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure an assessment and care planning process, after alternatives had been tried and documented in the resident's record for 1 of 1 sampled resident (Resident #2), who had a bed rails. The findings are:	C 453		

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C 453	Continued From page 12 Review of the facility's physical retraint policy revealed the facility was restraint-free and did not allow restraints in the facility. Observation on 01/24/20 at 9:15am during the initial tour revealed Resident #2 was lying in her bed with 1/2 length bed rails up on both side of her bed. Review of Resident #2's current FL2 dated 05/30/19 revealed diagnoses included unspecified dementia without behavioral disturbance and hypertension. Review of a physician's order dated 07/29/19 for Resident #2 revealed bedrails were to be used "at all times for safety of the resident" from the previous primary care provider (PCP) Review of a physician's order dated 08/16/19 for Resident #2 revealed resident was to have half rails on hospital bed for 'safety issues" from the previous PCP. Review of Resident #2's care plan dated 06/09/18 revealed: -Resident #2 totally dependent with transfers and ambulation. -There was no documentation of an assessment for bed rails. Review of Resident #2's record revealed there was no assessment or documentation of a care planning meeting for the use of bed rails. Review of a Licensed Health Professional Support (LHPS) evaluation for Resident #2 dated 01/15/20 revealed 'care of residents who physically restrained' was not listed as a current	C 453		

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C 453	Continued From page 13 task. Interview with Resident #2 on 01/24/20 at 10:30am revealed: -She had bed rails on her bed to assist her with turning and repositioning in the bed. -She did not know how to remove or lower the bed rails. -She relied on the staff to assist with positioning the bed rails. -She could not remember how often the bed rails were raised throughout the day. Telephone interview with Resident #2's Responsible Party (RP) on 01/24/20 at 11:37am revealed: -Resident #2 tried to get out of bed in July 2019 and fractured her left femur. -After the fall, she moved the hospital bed from her home into the facility. -The physician ordered bed rails on the bed and they had been present since ordered. -She had not signed a consent for Resident #2 to use bed rails because she did not know a consent was required. -She had not attended or been notified of a care planning meeting for the use of bed rails. Interview with the medication aide (MA) on 01/24/20 at 10:50am revealed: -He knew Resident #2 had bed rails on her bed. -He thought the resident used to rails to assist with repositioning because she used the rail during brief changes. -He had not received any specific instructions about how to use Resident #2's bedrails. -He had not observed Resident #2 lowering the bedrails on her own. -He had not observed Resident #2 attempting to get out of the bed.	C 453		

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(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 453	Continued From page 14 Interview with the Resident Care Coordinator (RCC) on 01/24/20 at 11:54am: -The bed rails were ordered by Resident #2's PCP. -The RP brought the bed and bed rails with her. -She did not consider the bed rails to be considered a restraint. -She did not know how often the bed rails were being raised for safety. -She was on leave when the order initially was written and did not know the specific instructions. -There had not been an assessment or care plan meeting completed for the bed rails. -Resident #2 was unable to lower bed rails on her own. -She did not know bed rails were a restraint and therefore did not complete an assessment. -She did not know if there were other alternative tried before bed rails were installed. Telephone interview with the Administrator on 01/24/20 at 3:40pm revealed: -He did not know Resident #2 had bed rails on her bed. -The facility's policy was restraints were not allowed in the building. Attempted telephone call with Resident #2's PCP on 01/24/20 at 2:35pm.	C 453		
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	C935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060135	A. BUILDING: _____ B. WING _____	R 01/24/2020

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C935	Continued From page 15 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 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.	C935		

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C935	Continued From page 16 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the medication aide 5, 10, or 15-hour training, the medication aide employment verification, or medication aide testing was completed for 1 of 3 sampled staff (Staff A). Review of Staff A's employee file revealed: -Staff A was hired on 07/30/18 as a medication aide. -Staff A had a medication clinical skills validation completed on 08/16/19. -There was no documentation of passing the medication aide test. -There no documentation of completing the 5-, 10-, or 15-hour medication aide training. -There was no medication aide employment verification completed. Interview with Staff A on 01/24/20 at 1:43pm revealed: -He was "rehired" by the facility in November 2019. -He had taken the Medication aide exam in December 2019 and did not pass. -He was scheduled to retake the medication aide exam next Tuesday, 01/28/20. -He had been passing medications in the facility for "awhile" and was passing medications today. -He thought he had completed the 5- and 10-hour medication aide training with a nurse who had came to the facility. -He did not know why there was no documentation of completing the 5- and 10-hour medication aide training in his record. Interview with the Resident Care Coordinator (RCC) on 01/24/20 at 1:55pm revealed:	C935		

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C935	Continued From page 17 -Staff A had worked in the facility since she had been hired. -A few months ago, he was "rehired" by the facility, but she did not recall him having a break in employment. -She thought if he did have a break in employment, it was very small, "maybe one pay period." -She thought Staff A had completed the 5- and 10-hour medication aide course. -A nurse consultant had come to the facility to provide training to medication aides, and she thought the trainings were included for staff who needed it. -She was not sure why there was no certificate of completion in Staff A's record. Interview with Staff A on 01/24/20 at 2:05pm revealed: -There was not a gap in his employment. -Facility management told him he was being rehired. Review of Staff A's employee record revealed no documentation reflecting that Staff A had been rehired by the facility or had a break in employment since originally hired on 07/30/18. Telephone interview with the Administrator on 01/24/20 at 3:45pm revealed: - He was not aware that Staff A had not yet passed the medication aide exam and had been passing medications in the facility. - The RCD was responsible for assuring all staffing requirements were met prior to staff working in the facility. - His understanding was that Staff A had been rehired and did not know if there was a gap in Staff A ' s employment. -He was not sure why Staff A was rehired.	C935		

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C935	Continued From page 18 -He was not aware there was no paperwork in Staff A's employee file reflecting that he had been rehired. - He was not aware that there was no documentation in Staff A's record of completing the required 5- and 10-hour medication aide course. - The RCD was responsible for assuring all staffing requirements were met prior to staff working in the facility.	C935		