STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068033	A. BUILDING: _____ B. WING _____	R 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE FAMILY CARE HOME # 2	313 SAW MILL ROAD CEDAR GROVE, NC 27231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(C 000)	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 03/05/20.	(C 000)	Decreasing the Capacity of Facility #2 was advised by building code person. Admin./ Owner were trying to follow rules. Admin./ Owner didn't realize it was not allowed with New license. Admin. will assure that this will not happen again.	3-10
C 015	10A NCAC 13G .0214 Suspension of Admissions 10A NCAC 13G .0214 Suspension of Admissions (a) Either the Secretary or his designee shall notify the domiciliary home by certified mail of the decision to suspend admissions. Such notice will include: (1) the period of the suspension, (2) factual allegations, (3) citation of statutes and rules alleged to be violated, (4) notice of the facility's right to contested case hearing or the suspension. (b) The suspension will be effective when the notice is served or on the date specified in the notice of suspension, whichever is later. The suspension will remain effective for the period specified in the notice or until the facility demonstrates to the Secretary or his designee that conditions are no longer detrimental to the health and safety of the residents. (c) The home shall not admit new residents during the effective date of the suspension. (d) Any action taken by the Division of Facility Services to revoke a home's license or to reduce the license to a provisional license shall be accompanied by a recommendation to the Secretary or his designee to suspend new admissions. A suspension may be ordered without the license being affected. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to comply with the Suspension of Admissions issued by the Adult Care Licensure	C 015		

Reviewed & Acknowledged
5-13-20 Darlene Kay Pe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 015	Continued From page 1 Section on 12/19/19 by having 1 additional resident (#2) currently living at the facility who was not identified by facility management as a current resident of the facility or a resident prior to the notification of the Suspension of Admissions. The findings are: The Division of Health Service Regulation (DHSR) issued a Suspension of Admissions (SOA) on 12/19/19, which was sent via certified mail. The certified mail was signed as delivered to the owner on 12/27/19, per united states postal service website. Observation on 03/05/20 at 9:45am during the initial tour of the facility revealed: -There were three bed rooms in the facility. -Bedroom #1 had a single bed and one resident. -Bedroom #2 had two twin beds and two residents. -Bedroom #3 had two twin beds and two residents. Interview with the Owner on 03/05/20 at 9:40am revealed: -She received the Suspension of Admissions notification by certified letter in January 2020. -Also, in January 2020, "the code enforcement people" came to the facility and told her that she had to install a ramp to replace the step up to the entrance of the main dining room and common living room. -After installing the ramp, the incline was too high for two of the female residents. -To prevent falls she moved the two female residents to the sister facility next door. -After moving the two residents into the sister facility, this caused the sister facility to be over the licensed capacity.	C 015		

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C 015	Continued From page 2 -To prevent the sister facility from being over capacity she moved one male resident from the sister facility to this facility. -She did not consider the move as being against the Suspension of Admissions. -She did not want to discharge any residents because the residents had lived at the facility for a long time. -In order to comply with what she was told by "code enforcement" moving residents was her only alternative. -She did not consider each home had a different license number and moving residents was considered a new admission. -She did not update any paperwork or change the admission dates for any of the residents that were moved. Interview with Resident #2 on 03/05/20 at 1:51pm revealed: -He slept at the facility, ate meals, showered and lived at the facility. -He moved into the facility at least one month ago. -He was not sure why he was moved into the facility but thought the move had something to do with "codes and regulations." Interview with the Administrator on 03/05/20 at 10:15am revealed: -Resident #2 was moved from one facility to another facility she did not consider the resident a brand-new admission. -The owner was trying to comply with the instructions given by the "code enforcement" people. -She was aware the facility was under a Suspension of Admissions.	C 015		

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C 204	Continued From page 3	C 204	Administrator and Medication Tech have Corrected all orders for Self-admin. All folders have been updated. Admin. has discussed with Med staff on rules and regulations of Sefadmin. residents. Administrator will assure all orders for Self-admin are in the file of Sf-admin residents monthly. Med staff	
C 204	10A NCAC 13G .0702 (c-1) Tuberculosis Test And Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination (c) The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (1) The examining date recorded on the FL-2 or MR-2 shall be no more than 90 days prior to the person's admission to the home. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure the examining date documented on the resident's FL2 was no more than 90 days prior to admission for 1 of 3 sampled residents (Resident #2). The findings are: Review of Resident #2's current FL2 dated 08/08/19 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD) and cardiovascular disease. -There was no order for the resident to self-administer his medications. Review of Resident #2's Resident Register revealed an admission date of 08/11/15. Review of Resident #2's record revealed there was no new FL2 or clarification of the resident's orders by the Primary Care Provider (PCP).	C 204		

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C 204	Continued From page 4 Interview with Resident #2 on 03/05/20 at 1:51pm revealed: -He could not recall the specific date that he moved into the facility but thought he lived at the facility for at least one month. Interview with the medication aide (MA)/Owner on 03/05/20 at 2:30pm revealed: -Maybe it had been one month since she admitted Resident #2 from to the facility from a sister facility. -She did not update Resident #2's FL2 or medication orders because she was unaware she needed to update the FL2. -She did not know she needed to update Resident #2's medication orders including the order to self-administer his medications. Attempted interview with Resident #2's PCP on 03/05/20 at 2:50pm was unsuccessful.	C 204	has been advised to review files every other week	
C 320	10A NCAC 13G .1002 (f) Medication Orders 10A NCAC 13G .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration, are reviewed and signed by the resident's physician or prescribing practitioner at least every six months This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all current orders for medications and treatments were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 1 of 3 sampled residents (Resident	C 320		

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C 320	Continued From page 5 #2). The findings are: Review of Resident #2's current FL2 dated 08/08/19 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD) and cardiovascular disease. -The Primary Care Provider (PCP) wrote orders for: Spiriva 18mcg (used to treat bronchitis and shortness of breath) inhale one puff in the morning, Symbicort (used to treat COPD) inhale two puffs twice daily, omeprazole 20 mg (used to treat acid reflux) one daily, and pro-air inhale two puffs every six hours as needed for shortness of breath. -There was no order for the resident to self-administer his medications. Review of Resident #2's record revealed: -The PCP wrote an order in September 2015 for Resident #2 to self-administer his medications. -Further review of Resident #2's record revealed no current order for the resident self-administer his medications. Observation of Resident #2's medications on hand at the facility on 03/05/20 at 1:50pm revealed: -The medications were not kept in the same locked area as other residents' medications. -Resident #2's medications were in the room with the resident. -Resident #2 had stored medications in an unlocked desk draw in his room. -The medications included: Spiriva inhaler, a Symbicort inhaler, a pro-air inhaler and over-the-counter omeprazole 20mg.	C 320		

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C 320	Continued From page 6 Interview with Resident #2 on 03/05/20 at 1:51pm revealed: -He could not recall the specific date he moved into the facility but thought he lived in the facility for at least one month. -Since his admission to the facility he had always self-administered his medications. -He kept his medications in the room with him and he monitored how he used his medications. -When he lived next door at the sister facility, he self-administered all his medications. -It had been six months since he had seen his PCP and he was not sure if the PCP had updated the order for him to self-administer his medications. Interview with the medication aide (MA)/Owner on 03/05/20 at 2:30pm revealed: -Resident #2 was admitted to the facility from a sister facility. -She did not obtain a current order for Resident #2 to self-administer his medications. -She did not know she needed to obtain an order for the resident to self-administer his medications when she moved him into the facility. Attempted interview with Resident #2's PCP on 03/05/20 at 2:50pm was unsuccessful.	C 320		
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	C 342	Med Staff and Admin. have updated MAR. 3-10 Med Tech has been instructed to correctly	

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C 342	Continued From page 7 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 obeervations, record reviews and interviews the facility failed to ensure the accuracy of the medication administration records for 2 of 3 sampled residents. (Residents #1 and #3). The findings are: 1. Review of Resident #1's current FL2 dated 12/30/19 revealed: -Diagnoses included diabetes mellitus Type II, seizure disorder and depression. -Physician orders included: -Atorvastatin (used for cardiovascular disease) 10mg every evening. -Calcium (used for calcium deficiency) 600mg, vitamin D 400mg twice daily. -Lisinopril (used to prevent high blood pressure) 5mg daily. -Sertraline (used for depression) 50mg every evening.	C 342	initial and document time on MAR. Admin. Will heavily monitor Med tech and MAR's to assure all recording of Medication Admin is done properly.	

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C 342	Continued From page 8 Review of Resident #1's January 2020 Medication Administration Record (MAR) revealed: -The administration times of the medication were documented as either am or pm with no specific times entered on the MAR. -Atorvastatin 10mg was documented as administered daily from 01/01/20 through 01/31/20 at "pm". -Calcium 600mg, vitamin D 400mg was documented as administered twice daily from 01/01/20 through 01/31/20 at "am and "pm". -Lisinopril 5mg was documented as administered daily from 01/01/20 through 01/31/20 at "am". -Sertraline 50mg was documented as administered daily from 01/01/20 through 01/31/20 at "pm". Review of Resident #1's February 2020 MAR revealed: -The administration times of the medication were documented as either am or pm with no specific times entered on the MAR. -Atorvastatin 10mg was documented as administered daily from 02/01/20 through 02/29/20 at "pm". -Calcium 600mg, vitamin D 400mg was documented as administered twice daily from 02/01/20 through 02/29/20 at "am and "pm". -Lisinopril 5mg was documented as administered daily from 02/01/20 through 02/29/20 at "am". -Sertraline 50mg was documented as administered daily from 02/01/20 through 02/29/20 at "pm". Review of Resident #1's March 2020 MAR revealed: -The administration times of the medication were documented as either am or pm with no specific times entered on the MAR.	C 342		

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C 342	Continued From page 9 -Atorvastatin 10mg was documented as administered daily from 03/01/20 through 03/04/20 at "pm". -Calcium 600mg, vitamin D 400mg was documented as administered twice daily from 03/01/20 through 03/04/20 at "am and "pm". -Lisinopril 5mg was documented as administered daily from 03/01/20 through 03/05/20 at "am". -Sertraline 50mg was documented as administered daily from 03/01/20 through 03/04/20 at "pm". Refer to interview with the Owner on 03/05/20 at 12:00pm. Refer to interview with a representative from the contracted pharmacy on 03/05/20 at 2:00pm. 2.. Review of Resident #3's current FL2 dated 01/10/20 revealed: -Diagnoses included bilateral lymphaderma, varicose veins, hypertension and venous insufficency. -Physician orders included: -Methimazole (used to treat hyperthyroidism) 5mg daily. -Metoprolol tartrate (used to treat hypertension) 5mg twice daily. -Doxycycline (used as an antobiotic) 100mg daily. Review of Resident #3's January 2020 Medication Administration Record (MAR) revealed: -The administration times of the medications was documented as "am" or "pm" with no specific times entered on the MAR. -Methimazole 5mg was documented as administered daily from 01/01/20 through 01/31/20 at "am". -Metoprolol tartrate 5mg was documented as	C 342		

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C 342	Continued From page 10 administered twice daily from 01/01/20 through 01/31/20 at "am" and "pm". -Doxycycline 100mg was documented as administered daily from 01/01/20 through 01/31/20 at "am" Review of Resident #3's February 2020 MAR revealed: -The administration times of the medications were documented as either "am" or "pm" with no specific times entered on the MAR. -Methimazole 5mg was documented as administered daily from 02/01/20 through 02/29/20 at "am". -Metoprolol tartrate 5mg was documented as administered twice daily from 02/01/20 through 02/29/20 at "am" and "pm". -Doxycycline 100mg was documented as administered daily from 02/01/20 through 02/29/20 at "am". Review of Resident #3's March 2020 MAR revealed: -The administration times of the medications were documented as either "am" or "pm" with no specific times entered on the MAR. -Methimazole 5mg was documented as administered daily from 03/01/20 through 03/05/20 at "am". -Metoprolol tartrate 5mg was documented as administered twice daily from 03/01/20 through 03/04/20 at "am" and "pm". -Doxycycline 100mg daily was documented as administered daily from 03/01/20 through 03/05/20 at "am". Refer to interview with the owner on 03/05/20 at 12:00pm. Refer to interview with a representative from the	C 342		

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C 342	Continued From page 11 contracted pharmacy on 03/05/20 at 2:00pm. _____ Interview with the Owner on 03/05/20 at 12:00pm revealed: -The contracted pharmacy printed the MARs, and had done so for 7 or 8 months. -Since the pharmacy started printing the the MARs, 7 or 8 months ago, the MARs had never had a specific time documented for medication administration. -Prior the the pharmacy printing the MARs, the facility staff had to hand write the MARs. -The handwritten MARs had the specific time of medication administration documented. -She did not know why the MARs did not have the time of medication administration documented. -She had not asked the pharmacy about this. Interview with a representative from the contracted pharmacy on 03/05/20 at 2:00pm revealed: -The pharmacy printed the MARs for the facility. -The pharmacy did not specify the times of medication administration. -The time of medication administration was determined by the facility. -The time of medication administration would be documented on the MARs when the facility determined what the times should be. -No one from the facility had notified the pharmacy about the medication administration times not being printed on the MARs.	C 342		
{C 350}	10A NCAC 13G .1005 (a) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are	{C 350}		

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{C 350}	Continued From page 12 competent and physically able to self-administer to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure 1 of 3 sampled residents (Resident #1) with a physician's assessment and order to self administer medications administered a fast acting insulin per sliding scale parameters as ordered. The findings are: Review of Resident #1's current FL2 dated 12/30/19 revealed: -Diagnoses included diabetes mellitus Type II, seizure disorder and depression. -A physician's order for Novolog sliding scale insulin (a fast-acting insulin used to treat elevated blood sugar) as follows:	{C 350}	Administrator has adivesd Med tech to assure that she looks to see if doseage of self-admin med. is Correct before resident self-admin the medication. Admin has been Monitoring this every day to insure the safty and health of our residents	3-15

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{C 350}	Continued From page 13 - < 150 = 0 units -151 - 200 = 2 units -201 - 250 = 4 units -251 - 300 = 6 units -301 - 350 = 8 units -351 - 400 = 10 units - > 400 = call MD -Resident will self-administer his Novolog with meals (breakfast, lunch and dinner). -Resident will bring his glasses to the table while eating to help him self administer his insulin. Review of Resident #1's March 2020 Medication Administration Record (MAR) revealed a documented entry as follows: - < 150 = 0 units -151 - 200 = 2 units -201 - 250 = 4 units -251 - 300 = 6 units -301 - 350 = 8 units -351 - 400 = 10 units - > 400 = call MD -The entry was documented "self". -The Novolog amount was not entered on the MAR. Observation of Resident #1 self-administering medications on 03/05/20 at 12:10pm revealed: -Resident #1 was sitting at the dining room table with his glasses on and his labeled glucometer. -The medication aide (MA) stood at his side to observe the self-administration of the insulin. -The finger stick blood sugar (FSBS) result was 179. -Resident #1 turned the insulin pen to 4 units. -Resident #1 cleaned the administration site with an alcohol soaked cotton ball. -Resident #1 self-administered 4 units of Novolog.	{C 350}		

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	FCL068033	A. BUILDING: _____ B. WING _____	R 03/05/2020

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{C 350}	Continued From page 14 Interview with Resident #1 on 03/05/20 at 12:12pm revealed: -He self-administered his fast acting insulin at meal times every day. -He administered the 4 units of Novolog because 179 was between 201 and 250, "just like it says" as he pointed to the insulin order. -He administered the 4 units of insulin because the insulin pen "wouldn't go any lower". -The insulin pen would not administer 2 units of insulin. Interview with the MA on 03/05/20 at 12:15 revealed: -Resident #1 had an order to self-administer the Novolog at meal times. -She was always at Resident #1's side when he self-administered his insulin. -Resident #1 always administered his insulin based on the order from the physician. -She did not know Resident #1 had just administered 4 units of Novolog. -Resident #1 should have self-administered 2 units of insulin. -She would notify the physician about the 4 units of insulin. Interview on 03/05/20 at 2:25pm with the nurse from Resident #2's physician's office revealed: -Resident #1 had an order to self-administer Novolog insulin at meal times. -The physician assessed Resident #1's ability to self-administer the sliding scale insulin on 12/30/19. -Per the physician order dated 12/30/19, with a FSBS of 179, Resident #1 should have administered 2 units of insulin and not 4 units. -If Resident #1 did not follow the order for self-administration of the Novolog, the outcome would be uncontrolled blood sugars.	{C 350}		

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(C937)	G.S. 131D-4.3 (a) ACH Training for Personal Care Aides G.S. 131D-4.3 (a) Adult care home training for personal care aides (2) A minimum of 80 hours of training for personal care aides. The training for aides shall be comparable to State-approved Certified Nurse Aide I training. The facility may exempt from the 80-hour training requirement any personal care aides who are or have been either licensed as a health care professional or listed on the Nurse Aide Registry. (3) Monitoring and supervision of residents. (4) Oversight and quality of care as stated in G.S. 131D-4.1. (5) Adult care homes shall comply with all of the following staffing requirements: a. First shift (morning): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents (licensed capacity or resident census) plus 3.0 hours for all other residents, whichever is greater; b. Second shift (afternoon): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents plus 3.0 hours for all other residents (licensed capacity or resident census), whichever is greater; c. Third shift (evening): 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). The facility shall provide staff to meet the needs of the facility's residents. Each facility shall post in a conspicuous place information about required staffing that enables residents and their families to ascertain each day the number of direct care staff and supervisors that are required by law to	(C937)	Administrater / Owner have assured that 3-10 Staff get correct 80-hour training. We have an R.N. that trains our Staff. The 80 hour training Course will be completed For each Staff member.	

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{C937}	Continued From page 16 be on duty for each shift for that day. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure that 2 of 3 staff sampled, the Owner/medication aide and Personal Care Aide (Staff B) who provide personal care to residents, had successfully completed the 80-hour personal care training and competency evaluation program within six months of hire. The findings are: 1. Review of the Owner's, personnel record revealed: -There was no hire date noted in the personnel record. -There was documentation the Owner had 25 hours of personal care aide training on 07/09/17. -There was no certification of personal care training and competency evaluation for an 80-hour training course. Interview with the Owner on 03/05/20 at 4:40pm revealed: -She had been the Owner of the facility since 2015. -She worked every day and lived in the sister facility adjacent to the facility. -She worked as the MA and personal care aide. -Her duties included medication administration, medication orders, maintaining resident and staff records, cooking, cleaning, and assisting residents as needed. -Two residents needed assistance with showering. -She did not remember when or where she received the personal care training.	{C937}		

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{C937}	Continued From page 17 2. Review of Staff B's, personal care aide (PCA) personnel record revealed: -There was no hire date noted in the personnel record. -There was documentation Staff B had 15 hours of personal care training on 02/18/15 for "Basic Person Care-Part 1 and 2". -There was no certification of personal care training and competency evaluation for an 80-hour training course. Interview with a resident on 03/05/20 at 3:00pm revealed: -Staff B helped him with showers on Mondays and Saturdays. -Staff B put soap all over his body and physically washed his body, shampooed his hair and shaved him. -Staff B also put lotion on his body after a shower and helped him get dressed. Interview with a second resident on 03/05/20 at 3:10pm revealed: -Staff B assisted him in and out of the shower. -Staff B shampooed his hair, soaped and washed his body. -After the shower Staff B applied lotion and helped him put his clothes and shoes on. -Staff B helped him with showering three times per week. Interview with Staff B on 03/05/20 at 3:45pm revealed: -She was the Supervisor-in-Charge at the facility -She had always worked at the facility since her family had owned it. -She worked as a personal care aide (PCA) and lived at the facility. -She thought she had personal care training at the facility.	{C937}		

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{C937}	Continued From page 18 -She thought the personal care training was done by a nurse. -She was not sure when she completed the training or how many hours were certified by the course. -There were 3 residents that needed assistance with bathing and dressing.	{C937}		
{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	{C992}	Administrator had hard time tring to get drug screenings for employees. All staff have recieved drug screenings at this time. Admin. will assure all New staff have drug screenings upon hire.	3-6

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{C992}	Continued From page 19 prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 2 of 2 staff sampled (the Administrator and Staff D) had completed an examination and screening for the presence of controlled substances upon hire. The findings are: 1. Review of the Administrator's personnel record revealed: -There was a hire date of 03/31/17. -There was no documentation of a completed controlled substance examination and screening. Interview with the Administrator on 03/05/20 at 10:00am revealed: -She did not have documentation for a controlled substance examination and screening because she did not complete a drug screen upon hire. -She was responsible for assuring all staff had the requirements for employment including drug screening and examination. Refer to interview with the Administrator on 03/05/20 at 10:00am. 2. Review of Staff D's, Personal Care Aide (PCA) personnel record revealed:	{C992}		

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(C992)	Continued From page 20 -There was a hire date of 12/14/19. -There was no documentation of a completed controlled substance examination and screening. Interview with Staff D on 03/05/20 at 11:20am revealed: -He had worked at the facility since December 2019 as a PCA. -He worked daily at the facility but his responsibilities varied. -He had not completed a drug screen but was not sure why. -The Administrator was responsible for drug screens and she would be able to explain why he did not have a drug screen. Refer to interview with the Administrator on 03/05/20 at 10:00pm. Interview with the Administrator on 03/05/20 at 10:00pm revealed: -She had attempted to obtain drug screens at the local lab company and doctor's office but was unable to do so because they required contracts with financial obligations which she did not have. -As a last alternative she planned to order the drug screens from the local pharmacy. -As of today 03/05/20 she and staff had not completed drug screens.	(C992)		