STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl035033	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HEART FAMILY CARE HOME	131 HUNTINGTON RD LOUISBURG, NC 27549

(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 an annual survey on August 5, 2021.	C 000		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled residents (#1 and #2) had completed two-step tuberculosis (TB) testing in compliance with the control measures for the Commission for Health Services. The findings are: 1. Review of Resident #1's current FL-2 dated 03/18/21 revealed diagnoses included schizoaffective disorder, bipolar type and catatonia. Review of Resident #1's Resident Register revealed an admission date of 03/19/20.	C 202		

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Review of Resident #1's tuberculosis (TB) skin test revealed:
-There was documentation of a chest x-ray completed on 03/18/20 and there was no evidence of tuberculosis.
-There was documentation of a TB skin test given on 03/18/21 and no documentation that the TB skin test was read.
-There was no documentation of a second TB skin test.

Interview with Resident #1 on 08/05/21 at 1:46 pm revealed:
-She thought she had a TB skin test completed in the hospital, but she did not recall the date.
-She thought she had a chest x-ray previously and it was negative for TB.
-She could not recall the date of the chest x-ray.

Interview with the Administrator on 08/05/21 at 12:10pm revealed:
-She knew Resident #1 had a chest x-ray upon admission.
-She did not schedule or request a TB skin test for Resident #1 after her admission to the facility.
-She did not arrange a TB skin test for Resident #1 because she thought the chest x-ray was all that was required.
-She knew Resident #1 had a TB skin test during a hospital admission in March 2021, but she did not have Resident #1's TB skin test read.
-Resident #1 had a chest x-ray upon admission because she refused a TB skin test.
-Resident #1 did not have a chest x-ray completed as a result of a positive TB skin test.

Refer to the interview with the Administrator on 08/05/21 at 2:46pm.

2. Review of Resident #2's current FL-2 dated

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C 202	Continued From page 2 06/16/21 revealed diagnoses included chronic schizophrenia, depression, learning disability, insomnia, hypertension, sleep apnea, and mild renal insufficiency. Review of Resident #2's Resident Register revealed Resident #2 was admitted on 06/10/21. Review of Resident #2's tuberculosis (TB) skin test revealed there was no documentation of a TB skin test. Interview with Resident #2 on 08/05/21 at 2:15pm revealed: -He thought he had a TB skin test completed before his admission to the facility. -The TB skin test was placed in his left forearm. Interview with the Administrator on 08/05/21 at 2:46pm revealed: -Resident #2 had a TB skin test and she thought it was in his record. -She called the hospital that Resident #2 was admitted from in June 2021 to request his TB skin test results. -She had to have a TB skin test result to admit him to the facility and she recalled reviewing Resident #1's TB skin test. Refer to the telephone interview with the Administrator on 08/05/21 at 2:46pm. _____ Interview with the Administrator on 08/05/21 at 2:46pm revealed: -The residents had their first TB skin test prior to admission, and the second TB skin test was completed by the primary care provider (PCP). -She was responsible for ensuring residents had a completed TB skin test upon admission to the facility.	C 202		

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C 240	10A NCAC 13G .0802(e) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 3 sampled residents (#2 and #3) had a care plan signed and dated by a physician within 15 days of completion of the resident's assessments. The findings are: 1. Review of Resident #2's current FL-2 dated 06/16/21 revealed diagnoses included chronic schizophrenia, depression, learning disability, insomnia, hypertension, sleep apnea, and mild renal insufficiency. Review of Resident #2's Resident Register revealed: -Resident #2 was admitted on 06/10/21. -Resident #2 was admitted from another family care home. Review of Resident #2's care plan dated 06/11/21 revealed there were no signatures and dates for the assessor certification and the physician authorization.	C 240		

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C 240	Continued From page 4 Telephone interview with the primary care provider's (PCP) nurse on 08/05/21 at 12:51pm revealed: -The last appointment with Resident #2 was a new patient visit on 06/16/21. -There was no office documentation in Resident #2's records of a care plan prepared for Resident #2 and signed by the PCP since his admission to the facility. Refer to telephone interview with the primary care provider (PCP) on 08/05/21 at 12:51pm. Refer to interview with the Administrator on 08/05/21 at 2:46pm. 2. Review of Resident #3's current FL-2 dated 01/25/21 revealed: -Diagnoses included schizoaffective disorder depressed type, and Type II diabetes. -Resident #3 was continent of bowel and bladder and needed assistance with bathing. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 01/25/21. Review of Resident #3's care plan dated 01/25/21 revealed there were no signatures and dates for the assessor certification and the physician authorization. Telephone interview with the primary care provider's (PCP) nurse on 08/05/21 at 12:51pm revealed: -The last appointment with Resident #3 was a follow-up visit on 06/09/21. -There was no office documentation in Resident #3's records of a care plan signed by the PCP	C 240		

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C 240	Continued From page 5 since his admission to the facility. Refer to telephone interview with the primary care provider (PCP) on 08/05/21 at 12:51pm. Refer to interview with the Administrator on 08/05/21 at 2:46pm. _____ Telephone interview with the primary care provider's (PCP) nurse on 08/05/21 at 12:51pm revealed there was no documentation of a request for the PCP's review and signature of a care plan within 15 days after being assessed for residents. Interview with the Administrator on 08/05/21 at 2:46pm revealed: -She knew a resident care plan was to be prepared for each resident. -She was not aware residents' care plans were required to be signed within 15 days of an assessment. -She did not prepare the care plans, but the Supervisor in Charge (SIC) prepared the resident care plans. -The SIC had more experience with preparing and completing resident care plans. -The SIC did not tell her care plans were to be signed by the PCP within 15 days of the assessment. -It was her responsibility to ensure resident care plans were completed and signed by the PCP.	C 240		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications,	C 330		

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C 330	Continued From page 6	C 330		

prescription and non-prescription and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents(#1) related to a medication used to treat hyperglycemia.

The findings are:

Review of Resident #1's current FL-2 dated 03/18/21 revealed:
-Diagnosis included schizoaffective disorder, bipolar type and catatonia.
-There was a medication order for metformin 500mg (used to treat high blood sugar) daily.

Review of Resident #1's medication orders revealed:
-There was a medication order dated 05/04/21 for metformin 1000mg take one tablet twice daily.
-There was a medication order dated 06/09/21 for metformin 500mg take one tablet twice daily.

Review of Resident #1's June 2021 printed medication administration record (MAR) revealed:
-There was an entry for metformin 1000mg take one tablet twice daily, scheduled for 8:00am and 8:00pm.
-There was documentation of administration of metformin 1000mg from 06/01/21 to 06/30/21 at 7:30am and 4:30pm.

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C 330	Continued From page 7 -There was no entry for metformin 500mg tablets. -There was no documentation of administration of metformin 500mg. Observation of Resident #1's medications in the facility on 08/05/21 at 11:40pm revealed: -There was one bubble package of metformin 500mg dispensed on 07/23/21. -There were 27 tablets remaining in the bubble package. Telephone interview with a representative at Resident #1's facility contracted pharmacy on 08/05/21 at 1:08pm revealed: -Resident #1 had an order dated 06/09/21 for metformin 500mg twice daily with meals. -Resident #1 had a previous order dated 03/26/21 for metformin 1000mg twice daily. -The dispense dates for metformin 1000mg tablets were 11/25/20 for 44 tablets, 12/03/20 for 120 tablets (30-day supply), 01/05/21 for 120 tablets, and 02/26/21 for 120 tablets. -The last dispense dates for metformin 1000mg was 02/26/21. -The dispense dates for metformin 500mg tablets were 60 tablets on 05/04/21 (30-day supply) and 60 tablets on 07/23/21. -On 06/19/21, 60 tablets of metformin 500mg were dispensed to the facility and the tablets were returned. -There was documentation that the Administrator indicated Resident #1's metformin 500mg was discontinued. -Three days later ,06/22/21, staff at the facility requested metformin 500mg tablets for Resident #1 and 60 tablets were dispensed on 06/22/21. Telephone interview with a nurse at Resident #1's primary care provider's (PCP) office on 08/05/21 at 12:51pm revealed:	C 330		

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C 330	Continued From page 8 -Resident #1's last visit with her PCP was 06/09/21. -There was a current order for metformin 500mg twice daily written on 06/09/21. Interview with Resident #1 on 08/05/21 at 1:46pm revealed: -She did not have diabetes. -Her PCP gave her tablets to prevent diabetes and she took them twice daily. Interview with the Administrator on 06/18/21 at 4:30pm revealed: -She and the Supervisor in Charge reviewed and transcribed medication orders. -If there was a medication order change, they ensured the previous dose was discontinued by the PCP. -She faxed orders to the pharmacy. -She attended medical appointments with residents and sometimes residents had tele-health visits. -Sometimes the PCP, wrote new orders but the PCP did not tell her about the new orders. -She had to call the PCP office to determine if any new orders were written for a resident. -She took Resident #1 to her appointment on 06/09/21, but she did not know Resident #1's metformin dose was changed until she reviewed Resident #1's July 2021 MAR -She contacted Resident #1's PCP to inquire about Resident #1's metformin and she received the order in July 2021. -She continued to administer metformin 1000mg to Resident #1 throughout the month of June 2021, because she was not aware of the new order for metformin 500mg. -She was responsible for ensuring medications were administered as ordered by the PCP.	C 330		

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C 342	Continued From page 9	C 342		
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 ensure the accuracy of medication administration records for 1 of 3 sampled residents (#2), including a medication used to treat constipation and a vitamin supplement. The findings are: 1. Review of Resident #2's current FL-2 dated 06/16/21 revealed diagnoses included chronic	C 342		

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C 342	Continued From page 10	C 342		

schizophrenia, depression, learning disability, insomnia, hypertension, sleep apnea, and mild renal insufficiency.

a. Review of Resident #2's current FL-2 dated 06/16/21 revealed there was a medication order for docusate 5 milliliters daily.

Review of Resident #2's June 2021 handwritten medication administration records (MAR) revealed:
-There was an entry for docusate 5 ml daily, without a scheduled time for administration.
-There was no documentation of administration of docusate from 06/10/21 to 06/30/21.

Review of Resident #2's July 2021 and August 2021 handwritten MARs revealed:
-There was an entry for docusate 5ml daily, scheduled for 8:00am.
-There was documentation of administration of docusate from 07/01/21 to 08/05/21 at 8:00am.
-There was documentation of refusals on 08/01/21 and 08/02/21 at 8:00am.

Observation of Resident #2's medications on hand on 08/05/21 at 11:55am revealed:
-There was one bottle of docusate with three tablets available for administration.
-The bottle was dispensed on 07/07/21 from a local pharmacy.
-There was also a 473ml bottle of liquid docusate dispensed on 06/30/21.
-The bottle of liquid docusate was ¾ full.

Interview with Resident #2 on 08/05/21 at 2:15pm revealed he took a stool softner.

Telephone interview with Resident #2's primary care provider (PCP) on 08/05/21 at 12:51pm

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C 342	Continued From page 11	C 342		

revealed:
-Resident #2's docusate was changed from liquid form to tablets on 07/07/21.
-Resident #2 requested the change for his docusate.

Interview with the Administrator on 08/05/21 at 2:46pm revealed:
-She did not know Resident #2's docusate was not documented as administered on Resident #2's June 2021 MAR.
-Resident #2 no longer wanted liquid docusate, but she kept the bottle of liquid docusate because she was waiting on a discontinue order for the liquid form.
-Resident #2 was admitted with a bottle of liquid docusate.

Refer to interview with the Administrator on 08/05/21 at 2:46pm.

b. Review of Resident #2's current FL-2 dated 06/16/21 revealed there was a medication order for multi-vitamin (MVI) 5 ml daily.

Review of Resident #2's June 2021 handwritten medication administration records (MAR) revealed:
-There was an entry for MVI 5 ml daily, without a scheduled time for administration.
-There was no documentation of administration of MVI from 06/10/21 to 06/30/21.

Review of Resident #2's July 2021 and August 2021 handwritten MARs revealed:
-There was an entry for MVI 5ml daily, scheduled for 8:00am.
-There was documentation of administration of MVI 5 ml daily from 07/01/21 to 08/05/21 at 8:00am.

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C 342	Continued From page 12 Observation of Resident #2's medications on hand on 08/05/21 at 11:55am revealed: -There was an opened over the counter bottle of MVI tablets. -There were 65 tablets of MVI in the OTC bottle. -There was no date of opening on the bottle of MVI tablets. Interview with Resident #2 on 08/05/21 at 2:15pm revealed he had taken a multi-vitamin since his admission to the facility in June 2021. Telephone interview with Resident #2's primary care provider (PCP) on 08/05/21 at 12:51pm revealed a prescription was provided for Resident #2's MVI on 07/19/21. Interview with the Administrator on 08/05/21 at 2:46pm revealed: -She reviewed the new MARs by comparing them to the old MARs. -She reviewed Resident #2's June 2021 MAR. -She did not know Resident #2's MVI was not documented as administered on Resident #2's June 2021 MAR. -She administered MVI to Resident #2 in June 2021. Refer to interview with the Administrator on 08/05/21 at 2:46pm. _____ Telephone interview with the Administrator on 08/05/21 at 2:46pm revealed: -The facility pharmacy provided MARs for the facility. -However, Resident #2 did not use the same pharmacy as the other residents. -She or the Supervisor in Charge (SIC) reviewed the next months' MARs and placed them in the	C 342		

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C 342	Continued From page 13 MAR book. -She reviewed the new MARs by comparing them to the previous months MARs. -She thought the SIC spilled a drink on Resident #2's June 2021 MARs and they had to be rewritten. -She thought the reason all of his medications were not documented as administered on the June 2021 MARs was because the MARs were rewritten and the documentation was missed. -She was responsible for ensuring residents' MARs were accurate.	C 342		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl035033	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HEART FAMILY CARE HOME	131 HUNTINGTON RD LOUISBURG, NC 27549

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C 612	Continued From page 14 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to use of personal protective equipment (PPE) face masks by staff to reduce the risk of transmission and infection. The findings are: Review of the Centers for Disease Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated 03/29/21 revealed: -Personnel should wear a face mask while in the facility and for protection during resident care encounters. -Personnel who worked in areas with minimal to no community transmission of the coronavirus should use a well-fitting face mask for source control. Review of the CDC Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination dated 04/27/21 revealed recommendations for use of personal protective equipment (PPE) by personnel was unchanged. Review of the North Carolina Department of Health and Human Services (NC DHHS) Guidance for Best Practices for Infection Prevention in Long Term Care Facilities (LTCFs)	C 612		

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C 612	Continued From page 15 dated 02/10/21 revealed LTCFs should follow the CDC guidance for appropriate selection and use of PPE. Observation of the facility upon entrance door on 08/05/21 at 8:11am revealed: -Staff came to the entrance door of the facility without a face mask. -There was signage on the storm door indicating the facility's screening process and COVID-19 precautions. -There was a screening station near the door with a thermal scan thermometer, a box of N-95 face masks, a box of surgical mask and a large bottle of hand sanitizer. -Staff performed screening related to COVID-19 without wearing a face mask. -There were two residents sitting in the living room. Interview with the personal care aide (PCA) on 08/05/21 at 8:17am revealed there were five residents who resided in the facility. Observation of the facility on 08/05/21 at 8:32am revealed the Administrator arrived at the facility wearing a face mask. Observation of the PCA in the facility on 08/05/21 at 8:35am revealed she was not wearing a face mask. Observation of the PCA in the dining area on 08/05/21 at 10:08am revealed she served snacks to three residents without a face mask. Observation of the facility on 08/05/21 at 10:30 am revealed the Administrator pulled her face mask below her chin.	C 612		

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C 612	Continued From page 16 Observation of another PCA on 08/05/21 at 2:15pm revealed: -She entered the living room area where three residents sat without a face mask. -After greeting the residents, she turned around and returned to the screening station. -The PCA returned from the screening station wearing a face mask. Interview with the PCA on 08/05/21 at 2:21pm revealed: -She had worked at the facility for one year. -There was a COVID-19 policy that she had read over. -She had received training concerning COVID-19 from a lady but she did not recall the date or where the lady worked. -The lady taught her to wash her hands, use hand sanitizer, and wear a face mask. -She washed her hands after every task she performed in the facility. -The resident wore a face mask when they left the facility to attend appointments. -When she arrived for work in the morning, she took her temperature, then documented it on the sign in log, and washed her hands. -PPE was used for protection from the spread of COVID-19. -She could not remember the CDC guidelines related to wearing a face mask. -She and all the residents were vaccinated. -She did not have a facemask on because she and the residents were vaccinated, and no one was exhibiting symptoms of COVID-19. -Staff used to wear face mask all the time and she stopped wearing a face mask. -She did not know the date she stopped wearing a face mask inside the facility. -The Administrator had not told her to wear a face mask on 08/05/21.	C 612		

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C 612	Continued From page 17 Interview with the Administrator on 08/05/21 at 2:46pm revealed: -There was a COVID-19 policy for the facility. -She expected staff to wear a face mask inside the facility even though everyone was vaccinated. -She thought if a person was vaccinated that they did not have to wear a face mask in the facility. -She thought the CDC guidelines were that people should wear a face mask but if a person was vaccinated it was not required. -She heard the CDC guidelines on the news, and she thought the CDC guidelines applied to everyone. -She did not know there were separate CDC guidelines for LTC concerning COVID-19. -She was responsible for ensuring the CDC guidelines related to the use of face masks were followed.	C 612		