PRINTED: 01/03/2022 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	AND FEAR OF CONTESTION		A. BOILDING			
		FCL001184	B. WING		12/0	8/2021
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST NDLY ROAD	TATE, ZIP CODE		
ELIA1 F	AMILY CARE HOME		TON, NC 272			,,
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	The Adult Care Lic initial survey on 12	ensure Section conducted an //08/21.				
C 145	10A NCAC 13G .0 Qualifications	406(a)(5) Other Staff	C 145			
	(a) Each staff per shall:	406 Other Staff Qualifications son of a family care home antiated findings listed on the				
	North Carolina He according to G.S.	alth Care Personnel Registry				
	Based on record r facility failed to en C) had no substar	net as evidenced by: reviews and interviews the sure 2 of 3 sampled staff (A and hitated findings on the North are Personnel Registry (HCPR)				
	The findings are:					
	Review of the faci license was effect	lity's license revealed the ive on 06/08/21.				
	Review of Staff Personal Care Aid revealed:	A's, Medication Aide (MA)/ de (PCA) personnel record				
	-There was docur	te of hire documented. nentation a HCPR check was ff A on 07/18/21 with no ngs.				
		one interview with Staff A on m was unsuccessful.				
	6:43pm revealed:					
LABORATO		/IDER/SUPPLIER REPRESENTATIVE'S SI		TITLE	3 <b>4</b>	(X6) DATE
$\underline{C}$		Sowa		DMINISTRATOR		ation sheet 1 of 1
STATE FO	KM		3088	NYVT11	ii comino	G. 311 311301 1 31 1

Division	of Health Service Re	egulation			(VA) DATE CURVEY
STATEMENT OF BETTOLES		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
AND FLAN	or connection		A. BUILDING.		
		FCL001184	B. WING		12/08/2021
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE	
		206 FRIEN	IDLY ROAD		
ELIA1 F	AMILY CARE HOME	BURLING	TON, NC 27		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
C 145	Continued From pa	age 1	C 145		01/12/22
	-Staff A's date of hi	re was 05/01/21.		As of 12/10/20	21
	-Staff A did not star	t working at the facility until		staff A is no lo	(KB 01/14/22
	October 2021.  -He was responsib	le for performing HCPR		staff 4 12 NO 10	riges
	checks on new em	ployees.		working at thi	S
	-He usually comple	eted HCPR checks upon hire		facility. The Adm	inistr-
	2. Review of Staff	C's, Medication Aide (MA)/		ator will see to	it
	Personal Care Aide revealed:	e (PCA) personnel record		that all fill-in s	taff
	-There was no date	e of hire documented.		will have a compl	ete
		cumentation a HCPR check		start folder just	as
	was completed for	Stan C.		regular staff de	9
		w with Staff C on 12/08/21 at		3,00	- 4
	5:44pm revealed:	sister facility, but she filled in at		Staff C filled in	@1
	this facility about 3			this facility a	
	-She remembered	filling in at the facility on			
	Thanksgiving Day of 12/04/21.	, 11/22/21, and on the weekend		result of a sta	
	-She did not reme	mber when she filled in at the		emergency. This	did
	facility prior to Nov	rember and December 2021. if a HCPR check was		not give the Ad	min-
	completed for her			nor give the via	+ + >
	I to the state of the state of	Administrator on 12/09/21 at		istrator enough	111100
	4:41pm revealed:	Administrator on 12/08/21 at		to complete full documention for	1000
	-Staff C's hire date	was June 2021.		documention for	Mer.
	-Staff C worked at	another one of his facilities, but facility in June 2021 and a few		Graina corward, al	l fill-
	other times as nee			Sold for the house	16
	-Staff C did not ha	ive a HCPR check upon hire at		Going forward, at in staff will har HCPR record at	
	the facility.	Staff C was okay to work at the		HCPR record at	any
	facility since she r	net all requirements at the other		facility they wor	k în.
	facility.				
1					

Division of Health Service Regulation  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		The state of the s	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL001184	B. WING		12/08/2021
	PROVIDER OR SUPPLIER	206 FRIE	NDLY ROAD	TATE, ZIP CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH		.D BE COMPLETE
	Qualifications  10A NCAC 13G .04 (a) Each staff persishall: (7) have a crimina accordance with G 131D-40;  This Rule is not m Based on record refacility failed to enshad a statewide cricompleted upon hith the findings are:  Review of the facil license was effectivense was effectivense was effectivense was no datance or the rewas no datance or the rewas no documbackground checker of the rewas no documbac	406(a)(7) Other Staff 406 Other Staff Qualifications on of a family care home I background check in .S. 114-19.10 and G.S.  et as evidenced by: eviews and interviews, the sure 1 of 3 sampled staff (A) iminal background check re.  ity's license revealed the ve on 06/08/21.	C 147	Criminal backgrow check had been formed by the stap in another sister for another sister forminal back grow checks will be when the staff me begins work in facility. Hence in this clocumental facility specific	-acility. all unol made ember any making tion
	background check -Staff A had a crin	ole for ensuring criminal ks were completed upon hire. hinal background check other one of his facilities but not ility			

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_ 12/08/2021 B. WING FCL001184 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD **ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 147 Continued From page 3 C 147 -He thought he could use the criminal background check from the other facility for this -Staff A administered medication and provided personal care to residents. C 246 C 246 10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure health care The Administrator was 01/12/22 referral and follow up for 1 of 3 sampled residents Scheduled to take resident (KB 01/14/22) related to a missed wellness appointment and a pulmonology appointment (Resident #1). #1 to her appointment. The findings are: However, as a result Review of Resident #1's current FL2 dated of the state survey by DHSR on 12/08/21, 11/09/21 revealed diagnoses included pneumonia, chronic obstructive pulmonary disease, and respiratory failure. the appointment was Review of Resident #1's physician's order dated 05/23/21 revealed an order for to referral to unfortunately not pulmonology. honored. Going forward, the admi-Interview with a receptionist at Resident #1's primary care provider's (PCP) office on 12/08/21 nistrator will make other at 11:33am revealed: arrangements on such -Resident #1 had an appointment for a wellness visit on today, 12/08/21 at 10:30am and was a "no days, in order for clients show." not to miss any -No one from the facility called to cancel or reschedule Resident #1's appointment.

Division of Health Service Regulation STATE FORM

Doctor's appointments.

Division of	of Health Service Re	gulation			(VO) DATE CUDVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL001184	B. WING		12/08/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE	
			DLY ROAD		
ELIA1 F	AMILY CARE HOME	BURLINGT	ON, NC 272		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETE
C 246	Continued From pa	ige 4	C 246	As a result of a	n
	-The PCP's office is appointment for Restaff of the appoint. The appointment is scheduled for 12/0 Interview with a requimonologist's off revealed: -Resident #1 had a pulmonologist for a 9:15amResident #1 was cone called to cance pulmonologist apport the appointment. Interview with Res 11:54am revealed: -She did not know today, 12/08/21, we-She knew she had dentist on today, because she was -She did not know the pulmonologist. There was no rea gone to the appointment. Her breathing way yesterday (12/07/2)  A second interview at 6:29pm revealed. Her PCP referred because she had being admitted to to make sure every breathing.	scheduled a pulmonology sident #1 and informed facility ment.  with the pulmonologist was 7/21 at 9:15am.  septionist at Resident #1's ice on 12/08/21 at 11:48am an appointment with the an initial visit on 12/07/21 at considered a "no show" as no sel or reschedule the cointment until around the time it.  ident #1 on 12/08/21 at she had an appointment on ith her PCP. If an appointment with the substantial with the not 12/07/21.  Is she had an appointment with on 12/07/21.  Is son why she could not have not ment with the pulmonologist. It is son why she could not have not ment with the pulmonologist. If it is not a pulmonologist been in the hospital prior to the facility and the PCP wanted bything was "okay" with her		emergency involvianother resident; another resident; another resident; another resident; appointment rescheduled on same day for Da 12/17/2021, resident in que was seen by pulmonologist. Groing forward, any emergency occurs, anit was appoint ments appoint ments the health and of all our residents continues to be utmost priority	point ed on was the 12/17. the, stion her when ituation ituation wellness lents our
		t a year since she was last seen			

Division of Health Service Regulation				CONCEDUCTION	(X3) DATE SU	JRVFY	
STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(XZ) MOETIFEE CONSTRUCTION				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _					
		FCL001184	B. WING		12/08	2021	
				TATE 710 000E			
NAME OF PROVI	DER OR SUPPLIER			TATE, ZIP CODE			
	206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217						
ELIA1 FAMIL	Y CARE HOME	BURLING	TON, NC 272				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
C 246 Cor	ntinued From pa	age 5	C 246				
12/-Th 05/ tha -Re and a h -St be -Re 12/-did to Int 12 -H - an -Re -Re for -Re to -H - an -Re -H - ar -H - ar	08/21 at 2:33pm le order for a pu 23/21 should ha t was the only v esident #1 had s d had Alpha 1 go igher risk for pu he thought it won monitored by a lesident #1 had a f08/21 for a Med not show up, a her.  erview with the code kept a schedule d transported the esident #1 had a pointment today r appointments so had an appoi he dentist's office besident #1 told ental appointment oth. e did not know schedule Resident pointment on yo le knew Resident pointment on yo le had an emerg nother one of his esident #1 to the esident #1 to	Ilmonologist referral dated ave been dated 11/23/21 as isit she had with Resident #1. If seen a pulmonologist previously enetic traits which placed her at ilmonary complications. In a pulmonologist, an appointment with her today, dicare wellness visit, but she and this was a little concerning.  Administrator on 12/08/21 at the ille of residents' appointments and the medical appointments and Medicare wellness and Medicare with her PCP, but were double booked as she and medical appointment for 2/07/21. The did not call him back until and 12/07/21 with the appointment.		As a result of to State visit on 15 the appointment unfortunately no honored. The approximate rescheduled 1/6/22. Resident was attended the healthcare professionals. The health and wellness of all residents remaindents rem	1/8, was, to pointment for by		

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ B. WING 12/08/2021 FCL001184 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD **ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 246 C 246 Continued From page 6 her pulmonologist appointment. -He rescheduled Resident #1's appointment with the pulmonologist, but he did not do so until around the time of the appointment because of the emergency with the other resident. C 288 10A NCAC 13G .0905(a) Activities Program C 288 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, interviews, and record reviews, the facility failed to implement a program of activities to promote the residents' active involvement with each other and the community. The findings are: Observation of the facility on 12/08/21 at various times between 10:15am to 1:15am and 2:30pm to 7:00pm revealed no activities were offered to the residents. Review of the activity calendar for December 2021 revealed: -The activity calendar for December 2021 was posted on the wall behind the dining table. -There were 14 hours of activities listed for each week in December 2021 and there was an activity scheduled daily. -Activities for the month of December 2021 included crafts, sing-a-long, drawing, spelling bee, church, walk around the block, toss ball, reading, name that tune, devotion-singing, movie

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Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_\_\_ 12/08/2021 B. WING FCL001184 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD **ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 288 Continued From page 7 C 288 time, dancing, word game, story time, movie quiz, ty church, sharing healthy tips, birthday party for the month, arts and crafts, board games, art day, chess, and playing cards. -The activity for 12/08/21 was walk around the block and was scheduled from 10:00am until 11:00am This facility had 01/12/22 Observation of the residents on 12/08/21 at various times between 10:15am and 7:00pm only one resident (x801/14/22)
For many months. -There was a resident laying on the couch in the living room. -There was a resident who left the facility for an appointment and returned. As a result, all -There was another resident who was dropped off at the store and returned. -There was one resident in bed throughout the activities were visit. -There was one resident visiting other residents in tailored to coloring their rooms. -There were two residents sitting in the living which the resident room. wanted to do daily. Interview with a resident on 12/08/21 at 10:24am revealed: -There were no activities offered in the facility, but When other residents she would like to participate in activities. -She was just talking to another resident this week about planning an outing for the two of were admitted, them. it offered the admi-nistrator the opport-unity to reintroduce activities daily. -She had not seen an activities calendar. Interview with a second resident on 12/08/21 at 10:29am revealed: -There had been no activities offered to residents since she was admitted to the facility about a -She wanted to do activities and thought volleyball

Division of	of Health Service Re	egulation			(X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			
		FCL001184	B. WING		12/08/2021
		CTDEET ADI	DRESS CITY S	STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			, , , , , , , , , , , , , , , , , , ,	
ELIA 1 FAMILY CARE HOME 206 FRIENDLY ROAD BURLINGTON, NC 27217					
LLIA I II			TON, NC 21		ION (VE)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 288	Continued From pa	age 8	C 288	The activity dir	rector
	10:33am revealed: -There were no aci- He would participal. He and another retthe bus to a local residents of the bus to a local residents during the started working 2021 and had not not not work and the started working room and work activities with the started working room and work are sidents preferred linterview with the started work activities	divities offered at the facility. In activities if offered. It is activities if offered. It is ident had just planned to take estaurant for an outing.  Medication Aide (MA)/Personal in 12/08/21 at 6:40pm revealed: were responsible for leading it is hift. In a in the facility in November seen an activity calendar for in December 2021. It is any activities with the interest working at the facility. It is some of the residents in the atched television and other in the atched television and other in the interest of the television and other in the interest was only 1 resident in the interest was only 1 resident in the interest in 14 hours of activities in conducting activities with because staff had been didays and taking care of the		has spent some time with stap members, to exthe importance keeping all reactive. Simple ties will contibe offered of these active include playing carols, chess a uno, coloring, monopoly amonopoly amonopoly amonopoly.	e f plain of sidents action nue to aily Some oities nol and
C992	2 G.S. § 131D-45 G and screening for	S.S. § 131D-45. Examination	C992		
	G S & 131D-45	Examination and screening for			

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Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_\_ 12/08/2021 B. WING FCL001184 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD **ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C992 C992 Continued From page 9 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 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 interviews and record reviews, the facility failed to ensure documentation of an examination and screening for the presence of controlled substances was completed for 3 of 3 sampled staff (Staff A, B, and C) prior to hire.

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	of Health Service Re	egulation	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED	
WIND LEWIN	01. 00111L011011	events on the second of the se				
		FCL001184	B. WING		12/08/2021	
	SPONING OF CLIPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		IDLY ROAD			
ELIA1 F	AMILY CARE HOME		TON, NC 27	217		
	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON (X5) LD BE COMPLETE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		
C992	Continued From pa	age 10	C992		01/12/22	
	The findings are:			All staff under	go the (K8 01/14/2)	
	-			la l		
	Review of the facil	lity's license revealed the		random middles		
	license was effecti	ive on 06/08/21.		drug test cor	colucted	
	1. Review of Staff	A's, Medication Aide			1 2 2 2	
	(MA)/Personal Ca record revealed:	re Aide (PCA), personnel		by the admini	s loager.	
	-There was no hire	e date listed for Staff A.		A photo graph	- OP	
	-There was a certi	ificate dated 05/01/21 for Staff A		11 1101 3119	0 0	
		successfully passed a random		A photo graph the test use	d cend	
	drug testThere was no documentation of the test batch			the results wi	ll be	
	number or test res	suits.			mon tel	
	Attempted telepho 12/08/21 at 5:44p	one interview with Staff A on m was unsuccessful.		property docu		
	1 1 1 1 1 1 1	Administrator on 12/08/21 at		This will be	done	
	1nterview with the	Administrator on 12/08/21 at Staff A's hire date was 05/01/21		TICIS WILL SC		
				religiously go	n ng	
		with the Administrator on				
	12/08/21 at 4:41p	m.		religiously go for ward.		
	2. Review of Staff	f B's, Medication Aide	100	A company ma	y be	
	(MA)/Personal Ca	are Aide (PCA), personnel			0	
	record revealed: -There was no hire date listed for Staff BThere was a certificate dated 11/10/21/21 for			used to supple	MIENT	
				In house drug te	sting.	
	Staff B document	ing she successfully passed a				
	random drug test.	•		This will be clone	by	
	-There was no do number or test re	ocumentation of the test batch		an external t	32 1-1	
	number of test re	ouno.				
1		aff B on 12/08/21 at 5:09pm		in the commun	ity.	
	revealed she rem	nembered doing a drug test at		Their results wil	1 ho	
	the facility in Augu	ust 2021, but she had not done a	а	saved in staff r	e combe	
drug test since she started working at the faction 11/26/21.				Saved in Stock !	~ (C)1000	

Division of Health Service Regulation				WO DATE OUDVEY	
STATEMENT OF BETTOTES OF THE PROPERTY OF THE P		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL001184	B. WING		12/08/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE	
		206 FRIEN	IDLY ROAD		
ELIA1 F	AMILY CARE HOME	BURLING	TON, NC 27		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE COMPLETE
C992	Continued From pa	ge 11	C992	Drug testing	
	Interview with the Administrator on 12/08/21 at 4:41pm revealed Staff B's hire date was 11/26/21.  Refer to interview with the Administrator on 12/08/21 at 4:41pm.  3. Review of Staff C's, Medication Aide (MA)/Personal Care Aide (PCA), personnel record revealed:  -There was no hire date listed for Staff CThere was no documentation of a drug screening.			be done by ein	
				A. It can be perinhouse with results and the batch numbers	the est
5:46pm revealed: -She worked at a sign the facility about 3 to -She last worked at		w with Staff C on 12/08/21 at sister facility, but she filled in at times. It the facility on last weekend. It drug screening at the facility.		B. Conducted by off site comp	nented. an
	4:41pm revealed: -Staff C's hire date -Staff C worked at she filled in at the other times as nee -Staff C did not ha facilityHe thought that S	another one of his facilities, but facility in June 2021 and a few		located with the communi-	io ty.
	Refer to interview 12/08/21 at 4:41pm revealed:	with the Administrator on m.  Administrator on 12/08/21 at ole for ensuring staff had drug			

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_\_\_ B. WING\_ 12/08/2021 FCL001184 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG **TAG** DEFICIENCY) C992 C992 Continued From page 12 -He completed drug screenings at the facility for staff. -He did not know he needed information regarding the test and results. -He thought the certificate was sufficient to document staff passing the drug test.

Division of Health Service Regulation