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{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 07/06/23.	{C 000}		
{C 131}	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE B VIOLATION Based on these finding, the previous Type B Violation was not abated. Based on record reviews and interviews, the facility failed to ensure 2 of 2 sampled staff (A and B) who administered medications met the requirements related to successfully completing 5-hour, 10-hour or 15-hour medication training course and passed the written medication aide examination prior to administering medications. The findings are: 1. Review of Staff A's, personal care aide (PCA), personnel record revealed: -There was documentation Staff A was hired in May 2006. -There was no documentation Staff A had completed the 5-hour, 10-hour, or 15-hour	{C 131}		

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medication aide (MA) training course.
-There was documentation Staff A completed the medication competency validation clinical skills checklist on 05/20/23.
-There was no documentation of an employment verification prior to hire as a MA.
-There was no documentation Staff A passed the MA written exam.

Interview with four residents on 07/06/23 at 8:05am revealed:
-Staff A administered their medications including eye drops and inhalers.
-Staff A administered eye drops in the morning and the evening the day before on 07/05/23.
-Staff A had administered inhalers the day before on 07/05/23 to a resident.
-Staff A administered medication in the morning, the afternoon and in the evenings.
-The Supervisor-in-Charge (SIC) administered medications when she was at the facility.
-Staff A administered them their medications because he was at the facility more than other staff.

Telephone interview with a contracted Registered Nurse (RN) on 07/06/23 at 1:43pm revealed:
-She had completed medication competency validation clinical skills checklist for all staff at the facility on 05/20/23.
-She did not provide 5-hour, 10-hour or 15-hour MA training for the staff.

Interview with Staff A on 07/06/23 at 8:00am and 9:59am revealed:
-He had worked at the facility for 15 years as a personal care aide (PCA).
-He worked from 6:00pm until 9:00am the next day.
-He was not a MA and had never taken the

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medication training course or taken the MA written exam.
-He did not recall completing the medication aide competency validation clinical skills checklist
-He did not have plans to take the medication aide training course or the written exam.
-He did not administer medication to the residents.
-The residents did not require mediation in the evening.
-The day time MA administered the residents their medications.

Interview with the on SIC on 07/06/23 at 8:45am revealed:
-She was a MA and worked Mondays through Fridays from about 8:30am to 7:00pm.
-Staff A did not administer medication to the residents.
-Staff A did not have the 5-hour, 10-hour or 15-hour training but had been competency validated for medication administration.
-A Registered Nurse (RN) had come to the facility and provided training for the staff on the administration of eye drops and diabetic care in May 2023.
-She did not know why the residents would say Staff A administered their medications.

Interview with the Administrator on 07/06/23 at 4:49pm revealed:
-Staff A was not a MA but had completed medication competency validation clinical skills checklist by an RN on 05/20/23.
-Staff A had not received any 5-hour, 10-hour or 15-hour medication aide training.
-She thought only the medication competency validation clinical skills checklist was required to administer medication.
-Staff A did not prepare the medications for

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administration from the medication cards but did administer medications to residents that had been pre-poured by another staff.
-She did not know about the eyedrops and inhalers; she thought the SIC administered them when she got to the facility.
-Staff A did not want to take any MA training or want to take the MA written exam.

2. Review of Staff B's, personal care aide (PCA) personnel record revealed:
-There was documentation Staff B was hired in October 2021.
-There was no documentation Staff B had completed the 5-hour, 10-hour, or 15-hour medication aide (MA) training course.
-There was documentation Staff B completed the medication competency validation clinical skills checklist on 05/20/23.
-There was no documentation Staff B passed the MA written exam.

Telephone interview with a contracted Registered Nurse (RN) on 07/06/23 at 1:43pm revealed:
-She had completed competency medication validation medication clinical skills checklist for all staff at the facility on 05/20/23.
-She did not provide MA 5-hour, 10-hour or 15-hour MA training for the staff.

Interview with four residents on 07/06/23 between 8:05am and 8:30am revealed Staff B administered their medications including eye drops and inhalers when she worked on the weekends.

Interview with the Supervisor-in-Charge (SIC) on 07/06/23 at 8:45am revealed:
-She was a MA and worked Mondays through Fridays from about 8:30am to 7:00pm; she did

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not work weekends.
-Staff B had not completed MA training but had been competency validated for medication administration and that was still "good" for a while.
-She thought Staff B could administer medication since she had the medication aide competency validation clinical skills checklist completed.
-She thought Staff B could administer medications for 60 days after the medication aide competency validation clinical skills checklist date.
-She did not know Staff B needed the 5-hour, 10-hour or 15-hour MA training as well.
-Staff B had not signed up for theMA written test and did not have plans to take the written test.
-An RN had come to the facility and provided training for the staff on the administration of eye drops and diabetic care in May 2023.

Interview with the Administration on 07/06/23 at 4:49pm revealed:
-Staff B had completed the medication competency validation clinical skills checklist on 05/20/23.
-Staff B administered medications to the residents on the weekends.
-Staff A did not initial the mediation administration record (MAR); the SIC documented on the MAR when she returned to work after the weekends.
-Staff B had not completed a 5-hour, 10-hour or 15-hour MA training and was not scheduled to take the MA written exam.
-She was not aware the weekend staff were required to complete the 5-hour, 10-hour or 15-hour MA training prior to administering medications to residents; she thought only full-time staff were required.

Attempted telephone interview with Staff B on

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{C 131}	Continued From page 5 07/06/23 at 5:35am was unsuccessful. Refer to tag .0330 10A NCAC 13G. .1004(a) Refer to tag .0335 10A NCAC 13G. .1004(f) Refer to tag .0341 10A NCAC 13G. .1004(i) The facility failed to ensure staff, who administered medications to residents, completed the MA training requirements before administering medications including the 5-hour, 10-hour, or 15- hour training class and had passed the MA written exam within 60 days of completing the medication competency validation clinical skills checklist which resulted in medication errors. This failure was detrimental to the health, safety and welfare of the residents and constitutes an Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/10/23 for this violation.	{C 131}		
{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, 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	{C 330}		

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{C 330}	Continued From page 6 interviews, the facility failed to administer medications as ordered by the physician for 1 of 3 sampled residents #3) related to an inhaler. The findings are: Review of Resident #3's current FL-2 dated 05/11/23 revealed: -Diagnosis included bipolar schizoaffective disorder, anxiety and asthma. -There was an order for Advair (used to treat asthma) 250/50 Discus inhale two puffs twice daily. Review of Resident #3's May 2023 medication administration record (MAR) revealed: -There was an entry for Advair (used to treat asthma) 250/50 Discus inhale one puff twice daily via discus scheduled at 8:00am and 8:00pm. -There was documentation Advair was administered twice daily from 05/01/23 to 05/31/23. Review of Resident #3's June 2023 MAR revealed: -There was an entry for Advair (used to treat asthma) 250/50 Discus inhale one puff twice daily via discus scheduled at 8:00am and 8:00pm. -There was documentation Advair was administered twice daily from 06/01/23 to 06/30/23 Review of Resident #3's July 2023 MAR revealed: -There was an entry for Advair (used to treat asthma) 250/50 Discus inhale one puff twice daily via discus scheduled at 8:00am and 8:00pm. -There was documentation Advair was administered twice daily from 07/01/23 to 07/05/23 and at 8:00am on 07/06/23.	{C 330}		

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{C 330}	Continued From page 7 Observation of Resident #3's medications on hand on 07/06/23 at 12:01pm revealed: -There was an Advair 250/50 Discus with 54 of 60 inhalations available for administration. -The Advair Discus was dispensed on 05/22/23. -There was label with a hand-written open date of 05/23/23 and instructions to discard after 30 days. Telephone interview with the pharmacist at the facility's contracted pharmacy on 07/06/23 at 2:07pm revealed: -Resident #3 had a current order for Advair 250/50 inhale one puff twice daily. -The Advair had been dispensed one time on 05/22/23. -There were 60 inhalations [puffs] in the inhaler; a thirty-day supply. -The facility staff had to request refills for the Advair because it was not on cycle fill. -There was an indicator that counted down inhalations as the inhaler was used; the number visible on the indicator was the number of inhalations available in the inhaler. -Advair was a combination inhaler which included a steroid and a beta agonist which opened the airways in the lungs as a preventative for asthma complications. -An outcome of not administering Advair as ordered could include difficulty breathing. Interview with Resident #3 on 07/06/23 at 5:23pm revealed: -He thought he was supposed to be administered his inhaler once a day in the evenings. -He inhaled one puff when he used his inhaler. -He knew he was using the inhaler correctly because he could feel the cool moisture go down his throat. -He was administered his inhaler that morning,	{C 330}		

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{C 330}	Continued From page 8 07/06/23. -He was not administered his Advair inhaler every day. -He had not had problems with breathing. Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 07/06/23 at 4:17pm revealed: -Resident #3 did not refuse his Advair inhaler. -The Advair had to be reordered from the pharmacy and was not on cycle fill. -She handed the Advair inhaler to Resident #3 to inhale to use himself; she stood beside him and watched him. -Sometimes she checked the number on the side of the discus and sometimes she forgot. -She did not know why there were still 54 puffs available for inhalation because she made sure it was administered twice daily. Interview with the Administrator on 07/06/23 at 5:05pm revealed: -She expected the staff to administer medications as ordered. -Resident #3's Advair was not administered as ordered if it was dispensed on 05/22/23 and had 54 puffs remaining on the indicator. Attempted interview with Resident #3's Primary Care Provider on 07/06/23 at 3:25pm was unsuccessful.	{C 330}		
{C 335}	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be	{C 335}		

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{C 335}	Continued From page 9 implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the resident's name and the name and strength of each medication prepared and protected from contamination and spillage for three residents.	{C 335}		

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{C 335}	Continued From page 10 The findings are: Observation of the medication cabinet on 07/06/23 at 8:45am revealed: -There were five plastic medication cups stacked inside of each other on the right-hand side of a shelf. -Each souffle cup contained multiple medications. -The medications cups were each labeled with a resident's name. -The medication cups were not labeled with the medication name or strength of the medications. -The medications were not sealed; the medication cups did not have a covering. Observation of the Supervisor-in-Charge/medication aide (SIC/MA) on 07/06/23 at 8:54am she administered medications to the residents from the medication cups from the medication cabinet. Interview with two residents on 07/06/23 at 8:30am revealed they were administered their medications at the kitchen table from cups with their names on them. Interview with the SIC/MA on 07/06/23 at 8:45am revealed: -She had just prepared the medication cups. -She prepared all the residents' medications for administration at one time by placing them into the cups. -She had stacked the cups into each other as she finished placing the medication in them. -She would go to each resident with the medication cup and administer them their medications. -She thought the medication cups only needed the resident's name on it.	{C 335}		

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{C 335}	Continued From page 11 Interview with the Administrator on 07/06/23 at 5:05pm revealed: -She knew the SIC/MA was pouring the residents medications into the medication cups ahead of time, but she thought the only information needed on the cup was the resident's name and the scheduled administration time. -She knew the cups required a lid or needed to be sealed. -She had instructed the staff to leave the medication in the sealed multidose bubble inside the medication cup with the resident's name on it because the multidose bubble had the medication name and strength. -The staff were instructed to open the multidose bubble as they administered the medication to each resident and compared the information on the multidose bubble to the MAR. -She was not aware the staff were opening more than one multidose packs for more than one resident at a time and placing them into the cups.	{C 335}		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	C 341		

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C 341	Continued From page 12 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the documentation on the medication administration records (MARs) included the initials of the medication aide (MA) who administered the medication to three residents. The findings are: Interview with three residents on 07/06/23 at 8:21am and 8:30am revealed: -There were multiple staff who administered medications to them. -There was one staff who only worked on the weekends and administered medications. -There were two staff who administered mediations during the week. Review of a three residents' medication administration records for the months of June 2023 and July 2023 revealed there was only one medication aide's (MA) initials had documented medication administration. Interview with the MA/SIC on 07/06/23 at 3:46pm revealed: -She signed all the MARs for all the residents. -She signed the MARs for the other staff because they had not passed the medication aide written test and she did not think they could sign on the MAR until they passed the exam. -The other staff left the MAR blank and when she came to work, she would initial them. -If a resident refused their medication, they would call her and tell her, and she would document it when she came to work. -She was constantly on the phone with the other staff and that is how she knew the medication	C 341		

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C 341	Continued From page 13 had been administered to the residents correctly. Interview with the Administrator on 07/06/23 at 4:49pm revealed: -She thought the staff who prepared the medications for administration was the one who had to document the administration on the MAR. -She knew the MAR was being signed by the SIC/MA after other staff had administered medications to the residents. -The other staff had not completed the written medication aide exam, so she thought they were not allowed to document on the MAR. -The SIC/MA was constantly on the telephone with the other staff and was available to answer questions.	C 341		
{C 353}	10A NCAC 13G .1006 (b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a medication for 1 of 3 residents (#2) were stored in a locked container in the refrigerator. The findings are: Observation of the kitchen on 07/06/23 from 8:50am to 9:00am revealed: -The refrigerator in the kitchen was not locked. -There was a cardboard box with a single unused	{C 353}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001113	A. BUILDING: _____ B. WING _____	R 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE	1718 MORGANTON ROAD BURLINGTON, NC 27217

(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 353}	Continued From page 14 dulaglutide (an injectable anti diabetic medication) pen in the refrigerator. -The cardboard box with the dulaglutide was in the front of a clear bin without a lid and no way of locking. -The clear bin was sitting on a shelf and contained other food items including hotdogs and bologna. -There were no staff in the kitchen. Review of Resident #2's current FL-2 dated 07/06/23 revealed: -Diagnoses included diabetes mellitus. -There was an order for dulaglutide .75 inject once weekly. Interview with the Administrator on 07/06/23 at 5:05pm revealed: -She knew medications required to be stored in the refrigerator needed to be locked. -She knew Resident #2 had a mediation that was stored in the refrigerator. -She forgot to get a box for Resident #2's dulaglutide injectable pen.	{C 353}		