

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001190	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/03/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIVINE SUPPORTIVE HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 VAUGHN 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 000}	Initial Comments A follow up survey was completed by the Adult Care Licensure Section on 04/03/24.	{C 000}		
{C 166}	10A NCAC 13G .0503(a) Medication Administration Competency Evaluati 10A NCAC 13G .0503 Medication Administration Competency Evaluation (a) The competency evaluation for medication administration shall consist of a written examination and a clinical skills validation to determine competency in the following areas: (1) medical abbreviations and terminology; (2) transcription of medication orders; (3) obtaining and documenting vital signs; (4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications; (5) infection control procedures; (6) documentation of medication administration; (7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions; (8) medication storage and disposition; (9) rules pertaining to medication administration in adult care facilities; and (10) the facility's medication administration policy and procedures.	{C 166}		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001190	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/03/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIVINE SUPPORTIVE HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 VAUGHN 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 166}	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION</p> <p>Based on these findings, the previous Type B Violation was not abated. Non-compliance continues.</p> <p>Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff A), who administered medications, had successfully passed the written state medication administration examination before administering medications to residents.</p> <p>The findings are:</p> <p>Review of Staff A's, personal care aide (PCA), personnel record revealed:</p> <ul style="list-style-type: none"> -There was no hire date available. -There was documentation Staff A completed the 15-hour medication aide training course on 01/17/24. -There was documentation Staff A completed the medication clinical skills checklist on 01/21/24. -There was no documentation Staff A passed the state medication administration examination. <p>Review of residents' February 2024, March 2024, and April 1-3, 2024 medication administration records(MAR) revealed:</p> <ul style="list-style-type: none"> -There was documentation Staff A administered medications on 22 days from 02/01/24 to 02/29/24. -There was documentation Staff A administered medications on 23 days from 03/01/24 to 02/29/24. -There was documentation Staff A administered medications on 3 days from 04/01/24 to 04/03/24. 	{C 166}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001190	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/03/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIVINE SUPPORTIVE HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 VAUGHN 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 166}	<p>Continued From page 2</p> <p>Interview with Staff A on 04/03/24 at 9:30am revealed:</p> <ul style="list-style-type: none"> -He began working at the facility sometime in January 2024. -He completed the 15-hour medication aide training course in January. -He completed the medication clinical skills checklist on 01/21/24. -He had not completed the state medication administration examination. -He attempted to take the state medication administration examination in early February, again in March, and again in April. -He administered medications to the residents in the facility <p>Interview with a resident in the facility on 04/03/24 at 8:45am revealed Staff A administered medications to him almost every day.</p> <p>Interview with the Administrator on 04/03/24 at 11:32am revealed:</p> <ul style="list-style-type: none"> -Staff A was hired in January 2024 as a PCA. -Staff A completed the 15-hour medication aide training on 01/17/24 and the medication clinical skills checklist on 01/21/24. -Staff A administered medications to the residents in the facility. -Staff A had attempted the medication administration examination in early February, again in March and in April, but had not passed the medication administration examination yet. <p>The facility's failure to ensure staff who administered medications to residents completed and passed the medication administration examination resulted in possible medication errors. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.</p>	{C 166}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001190	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/03/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIVINE SUPPORTIVE HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 VAUGHN 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 166}	Continued From page 3 _____The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/03/24 for this violation.	{C 166}		