STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-938	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL'S LOVING CARE, INC	1114 SHAW ST 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
V 000	INITIAL COMMENTS An annual survey was completed on June 14, 2023. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 5 and currently has a census of 1. The survey sample consisted of audits of 1 current client.	V 000		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing	V 117		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-938	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL'S LOVING CARE, INC	1114 SHAW ST 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
V 117	Continued From page 1 practitioner. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain a packaging label for a prescribed medication for 1 of 1 client (Client #1). The findings are: Observation on 6/13/23 at 12:40 pm of Client #1's medications revealed: -One Symbicort Inhaler 160 micrograms (mcg)-4.5 mcg -No packaging label for this medication was present with the client's name, the prescriber's name, current dispensing date, directions for administration, expiration date, the name, address and phone number of the dispensing pharmacy and the name of the dispensing practitioner. Review on 6/13/23 of Client #1's record revealed: -Date of Admission: 4/25/22 -Diagnoses: Decreased Intellectual Functioning, Schizophrenia, Hypertension, Mictocytic Anemia, Hyperlipidemia, Chronic Pain, and Bladder Spasms -A physician order on 11/10/22 for Symbicort Inhaler 160 mcg-4.5 mcg-inhale 2 puffs twice daily (for breathing). Interview on 6/13/23 with Staff #1 revealed: -"The instructions are there on the MARs (Medication Administration Records)." -"She (Client#1) uses it (Symbicort) to help with	V 117		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-938	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL'S LOVING CARE, INC	1114 SHAW ST 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
V 117	Continued From page 2 her breathing." Interview on 6/13/23 with Staff #2 revealed: -Did not realize the box the Symbicort came in had to be kept -Would make sure it was kept in a package with a label from the pharmacy. Interview on 6/13/23 with the House Manager revealed: -Client #1 had an inhaler prescribed by her doctor because of breathing issues related to her "weight gain and her having smoked." -Agreed the inhaler needed to be packaged with a label for administration.	V 117		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name;	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-938	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL'S LOVING CARE, INC	1114 SHAW ST 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
V 118	Continued From page 3 (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure medications were administered on the written order of a person authorized by law to prescribe medications affecting 1 of 1 client (Client #1). The findings are: Reviews on 6/13/23 and 6/14/23 of Client #1's record revealed: -Date of Admission: 4/25/22 -Diagnoses: Decreased Intellectual Functioning, Schizophrenia, Hypertension, Mictocytic Anemia, Hyperlipidemia, Chronic Pain, and Bladder Spasms -Physician-ordered medications: -11/10/22, Symbicort Inhaler 160 micrograms (mcg)-4.5 mcg-inhale 2 puffs twice daily (breathing) -1/5/23, Nicotine Patch 7 milligrams (mg)/24 hour-apply 1 patch topically once daily (tobacco cessation) -2/28/23, Ingrezza Capsule (cap) 40 mg- 1 cap once daily (mental disorder)	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-938	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL'S LOVING CARE, INC	1114 SHAW ST 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
V 118	Continued From page 4	V 118		

-3/10/23, Imiquimod Cream 5%-apply to genital warts 3 times a week at bedtime
-3/22/23, Haloperidol Tablet (tab) 10 mg, 1 tab 3 times daily (mental disorder)
-8/26/22 and 6/6/23, Latanoprost Solution 0.005% Solution-instill 1 drop each eye every evening (eye pressure)
-6/6/23, Podofilox Solution 0.5% cream-apply 1 application twice daily for 3 days, stop for 4 days then repeat weekly cycle (genital warts).

Review on 6/14/23 of Client #1's April 2023 MAR revealed blanks for the following medications with no staff initials circled or charting codes and no notes that explained the blanks:
-Nicotine Patch at the 8:00 morning (am) dosage time on 4/6/23 to 4/12/23, 4/14/23 to 4/19/23, and 4/21/23 to 4/23/23
-Ingrezza at the 8:00 am dosage time on 4/29/23 and 4/30/23
-Imiquimod Cream (no specified time or day for three times a week) for the week of 4/9/23 through 4/15/23 and the week of 4/16/23 through 4/22/23 for a total of 4 missed opportunities for administration of this medication
-Haloperidol at the 8:00 evening (pm) dosage time on 4/30/23
-Latanoprost Solution at the 8:00 pm dosage time on 4/1/23 through 4/30/23.

Review on 6/14/23 of Client #1's May 2023 MAR revealed blanks for the following medications with no staff initials circled or charting codes and no notes that explained the blanks:
-Symbicort Inhaler at the 8:00 am and 8:00 pm dosage times on 5/8/23 through 5/17/23
-Ingrezza at the 8:00 am dosage time on 5/3/23 through 5/31/23 with a line drawn through the medication name
-Latanoprost Solution at the 8:00 pm dosage time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-938	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL'S LOVING CARE, INC	1114 SHAW ST 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
V 118	Continued From page 5 on 5/4/23 through 5/31/23 -Imiquimod Cream had blanks for the weeks of 5/1/23 to 5/6/23, 5/7/23 to 5/13/23, and 5/14 to 5/20/23 for a total of 3 missed opportunities for administration of this medication. Review on 6/14/23 of Client #1's June 2023 MAR revealed blanks for the following medications with no staff initials circled or charting codes and no notes that explained the blanks: -Ingrezza at the 8:00 am dosage time from 5/1/23 through 5/31/23 -Latanoprost Solution at the 8:00 pm dosage time from 5/1/23 through 5/5/23 -Podofilox Solution at the 8:00 am and 8:00 pm dosage times from 6/6/23 through 6/14/23 Observation on 6/13/23 at 12:40 pm revealed: -No Podofilox Solution 0.5% cream was present in the facility Interview on 6/13/23 with Client #1 revealed: -She took medicine every day for her schizophrenia, diabetes and high blood pressure -Staff gave her medicine to her and she took one of her pills for her schizophrenia to her day program for the 12:00 p.m. dose -She had not refused any of her medications -She did not remember being without any of her medications -"I don't remember what all medicine I take except I do make sure I take my diabetes medicine by 5:00 every day" -She had no problems with any of her medications that she knew of. Interview on 6/13/23 with Staff #1 revealed: -She was hired in May 2023 and did not know how to answer about the blanks on the MARs -Client #2's Podofilox was "just ordered" on	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-938	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL'S LOVING CARE, INC	1114 SHAW ST 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
V 118	Continued From page 6 6/6/23 and had not been delivered by the pharmacy. The pharmacy was waiting for prior approval. Interview on 6/13/23 with the House Manager (HM) revealed: -Had been the HM at the facility for 6 years -Her job duties included scheduling client doctor appointments, transporting clients to their appointments, talking with clients' doctors and the pharmacy about any client medication changes -If Client #1 had prescribed medication that had not been delivered to the facility, it was because the pharmacy was waiting for her insurance to approve the medication -Client #1 had a new prescription for a cream that the pharmacy was waiting for authorization to be filled -She did not recall when she last spoke with the pharmacy about the status of Client #1's Podofilox Solution 0.5% cream. Interview on 6/14/23 with the Qualified Professional (QP) revealed: -Her QP duties included checking the medications and MARs for accuracy -She visited the facility at least once a month and her last visit was on Sunday, 6/11/23, for a house meeting -Areas she identified as needing improvement included making sure staff signed off on the MAR after administering Client #1's medicine, and making sure all the doctor orders for the medicines were at the facility -The HM was responsible for following up with the pharmacy on medication refills and orders -The Licensee was checking with the pharmacy to schedule medication administration refresher training for all the staff -She would make sure all staff completed this	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-938	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL'S LOVING CARE, INC	1114 SHAW ST 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
V 118	Continued From page 7 refresher training. Interview on 6/14/ 23 with the Licensee revealed: -The Imiquimod Cream was ordered from Client #1's former medical provider and she had been using the cream since her admission for her genital warts -Client #1 had this cream applied as prescribed -The Podofilox was a new prescription ordered on 6/6/23 by Client #1's current medical provider and was to replace the Imiquimod Cream -The doctor sent in the order (for Podofilox) to the pharmacy and the pharmacy had let her and the HM know (on unknown date) they were working with the doctor on prior approval -The pharmacy would let her or her staff know if the medication got approved when they delivered the medication to the facility -"I talked to the pharmacy yesterday and they said it (Ingrezza) had been approved. She received her medication in April but evidently, it has not been re-instated" -"I don't know why there are blanks on the MARs for the other medications. I don't see notes or explanations" -"The pharmacy we use does medication training. I called the pharmacy yesterday and asked for slots to get my staff refresher training on medication administration and the MARs. I am waiting to find out how many training slots I can get. The pharmacy does the training once a month."	V 118		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a	V 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-938	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL'S LOVING CARE, INC	1114 SHAW ST 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
V 131	Continued From page 8 health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to access the North Carolina Health Care Personnel Registry (HCPR) prior to the date of hire for 3 of 3 staff (Staff #1, Staff #2 and the Qualified Professional (QP)). The findings are: Review on 6/13/23 of Staff #1 personnel record revealed: -Date of Hire: 5/1/23 -Date HCPR accessed: 5/1/23. Review on 6/13/23 of Staff #2's personnel record revealed: -Date of Hire: 12/29/21 -Date HCPR accessed: 12/29/21 Review on 6/13/23 of the QP's personnel record revealed: -Date of Hire: 7/15/21 -Date HCPR accessed: 7/16/21 Interview on 6/14/23 with the Licensee revealed: -Thought the Health Care Personnel Registry (HCPR) could be accessed on a new employee's date of hire -Would ensure the HCPR was accessed prior to a new employee being hired.	V 131		