STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL039011	A. BUILDING: _____ B. WING _____	08/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS FAMILY CARE HOME	408 MIMOSA STREET OXFORD, NC 27565

(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 3-4, 2017.	C 000		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interview, the facility failed to assure 1 of 2 staff (Staff B) had no substantiated findings listed on the Health Care Personnel Registry (HCPR) upon hire according to G.S. 131E-256. The findings are: Review of Staff B's personnel record revealed: -There was no hire date documented for Staff B. -Staff B was hired as a housekeeper, cook, and transport staff. -There was no documentation in Staff B's record for a HCPR check at the time of hire. Interview on 8/04/17 at 2:35 pm with Staff B revealed: -She was hired in May 2017, but did not remember the date. -Her duties were to help around the house. -She did the housekeeping and cooking for	C 145		

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C 145	Continued From page 1 residents. -She would take residents shopping once a week. -She did not do personal care for the residents; the Administrator did that. Interview on 8/04/17 at 3:35 pm with the Administrator revealed: -She had not done a HCPR check for findings for Staff B. -Staff B was not a hands-on personal care aide. -Staff B was hired as a housekeeper and the Administrator did not think a registry check was needed. -The Administrator was responsible for obtaining the HCPR check for Staff B. -The Administrator would obtain the HCPR check for Staff B that afternoon. The HCPR check for Staff B was not provided by the end of the survey. _____ The facility failed to assure that no substantiated findings were listed on the North Carolina Health Care Personnel Registry upon hire for one staff. This failure was detrimental to the safety and welfare of the residents by not knowing if staff had findings of abuse or neglect listed on the registry upon hire and constitutes a Type B violation._____ The facility's Plan of Protection dated 8/04/17 revealed:: -I (Administrator) will have health care (personnel) registry checks as soon as possible for staff and for new staff going forward prior to hire. -Staff HCPR will be completed by 8/04/17 (today). -Going forward, I (Administrator) will check the HCPR for each hire prior to hiring. -Going forward, I (Administrator) will have a check list in place to ensure I have all of the	C 145		

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C 145	Continued From page 2 requirements for qualified staff in place. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 18, 2017.	C 145		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interview, the facility failed to assure 1 of 2 staff (Staff B) had a criminal background check in accordance with G. S. 114-19.10 and 131D-40. The findings are: Review of Staff B's personnel record revealed: -There was no hire date documented for Staff B. -She was hired as a housekeeper, cook, and transport staff. -There was no documentation in her records for a criminal background check at the time of hire. Interview on 8/04/17 at 2:35 pm with Staff B revealed: -She was hired in May 2017, but did not remember the date. -Her duties were to help around the house; the Administrator provided personal care and	C 147		

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C 147	Continued From page 3 medication administration. -She did the housekeeping and cooking for residents. -She would take residents shopping once a week. -She remembered being asked by the Administrator about having a criminal background check, but nothing was done. -She did not remember signing a consent for a background check. Interview on 8/04/17 at 2:25 pm with the Administrator revealed: -Staff B was hired in May, 2017; she did not remember the date. -A criminal background check was not done for Staff B. -The Administrator was responsible for the operation of the facility. -The Administrator was concerned about the staff's background; "it just slipped my mind". -The Administrator was responsible for obtaining a criminal background check on staff prior to hiring. -The Administrator would obtain a criminal background check on Staff B as soon as possible. _____ The facility failed to ensure that 1 staff had a criminal background check in accordance with G. S. 114-19,10 and 131D-40 upon hire. This failure was detrimental to the safety and welfare of the residents by not knowing if the staff had a history of criminal behavior upon hire and constitutes a Type B Violation. _____ The facility's Plan of Protection dated 8/04/17 revealed: -I (Administrator) will have background (checks) for staff completed by 8/11/17 to ensure the safety of the residents.	C 147		

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C 147	Continued From page 4 -Going forward, I (Administrator) will have a criminal background check on all new hires prior to hire. -Going forward, I (Administrator) have a check list in place to ensure background checks are completed for staff prior to hire. -I (Administrator) will use a check list to ensure the (staff) qualifications are completed. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 18, 2017.	C 147		
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 review and interview, the facility failed to ensure each resident, upon admission, was tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services for 1 of 4 sampled residents (Resident #3). The findings are:	C 202		

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C 202	Continued From page 5 Review of Resident #3's current FL-2 dated 10/31/16 revealed diagnoses of schizophrenia, anxiety, depression, hypertension, mild mental retardation, and asthma. Review of Resident #3's Resident Register revealed an admission date of 6/13/15. Record review for Resident #3 revealed: -There was a physician's office memorandum, signed by the physician, dated 6/12/16 verifying the resident had a negative Tuberculin (TB) test on 6/10/16. -There was no documentation Resident #3 had a second TB test. Interview on 8/03/17 at 4:15 pm with Resident #3 revealed: -The resident did not remember if she had a 2nd TB test. -She did not know about needing a 2nd TB test for being admitted to the facility. Interview on 8/04/17 at 9:25 am with Resident #3's physician's nurse revealed: -There was only the one TB test documented in Resident #3's records. -The resident had showed no signs or symptoms of having TB; there was no documentation that Resident #3 had any respiratory disease or infections. Interview on 8/04/17 at 9:35 am with the Administrator revealed: -Resident #3 was admitted having her 1st TB test and the Administrator thought the resident had both tests done. -If documentation for a 2nd test was not in her records, then the test was not done.	C 202		

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C 202	Continued From page 6 -Two step TB testing was required for admission to the facility. -The Administrator was responsible for assuring residents had 2 step testing for admission. -Resident #3 would be taken to her physician's office and have the 1st and 2nd steps of testing done.	C 202		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the Licensed	C 254		

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C 254	Continued From page 7 Health Professional Support (LHPS) evaluations were completed quarterly including a physical assessment for 4 of 5 sampled residents (#1, #2, #3, and #4) who required nebulizer treatments and collecting and testing of finger stick blood sugars (FSBS) (Resident #1); collecting and testing of FSBS and medication administration through injections (Resident #2); nebulizer treatments (Resident #3); and collecting and testing of FSBS (Resident #4). The findings are: 1. Review of Resident #1's current FL-2 dated 10/21/16 revealed diagnoses included schizophrenia, diabetes Type II, glaucoma, hypertension, and allergic rhinitis. Review of physician's orders for Resident #1 revealed: -There was an order dated 10/31/16 for Albuterol sulfate 1.25 mg/3ml, inhale (1) vial via nebulizer every 6 hours as needed. -There was an order dated 12/20/16 for FSBS before breakfast every week to be done on Wednesday. Review of Resident #1's LHPS Evaluations & Quarterly Reviews revealed: -There was an LHPS initial evaluation completed on 8/31/16 with tasks for inhalation medication by machine and collecting and testing of FSBS. -There was an LHPS evaluation completed on 11/11/16 with tasks for inhalation medication by machine and collecting and testing of FSBS. -There were no quarterly reviews for February 2017 or May 2017. Interview on 8/04/17 at 4:50 pm with Resident #1 revealed:	C 254		

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C 254	Continued From page 8 -She would use her nebulizer when she had some shortness of breath, but that was not very often. -She used the nebulizer once in a while; she did not remember the last time she used it. Interview on 8/04/17 at 9:25 am with Resident #1's primary care provider revealed the resident's last office visit was on 2/15/17; there were no changes made in the resident's care. Refer to interview on 8/04/17 at 10:05 am with the Administrator. 2. Review of Resident #2's current FL-2 dated 1/24/17 revealed diagnoses included type II diabetes, cervical disc disorder with myelopathy, generalized muscle weakness, gastroesophageal reflux and dysphagia. Review of Resident #2's Resident Register revealed an admission date of November 2007 (no day given); the resident was readmitted on 1/25/17 from rehabilitation. Review of Resident #2's physician's order dated 6/15/17 revealed: -There was an order for Novolog Insulin 100 units/ml, inject 6 units before each meal. -There was an order for accuchecks to be done three times daily. Interview with Resident #2 on 8/03/17 at 11:30 am revealed: -He was diabetic. -He had been diabetic for a long time. -He got his blood sugar checked 3 times a day. -He got insulin in his arm depending on his blood sugar. -He did not get insulin every day.	C 254		

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C 254	Continued From page 9 Review of Resident #2's LHPS Evaluations & Quarterly Reviews revealed: -There was an LHPS evaluation completed on 8/31/16 with tasks for collecting and testing of FSBS and medication through injection. -There was no LHPS Review for November 2016 for Resident #2; he was at a rehabilitation facility for surgery. -An LHPS review had not been completed since the resident returned to the facility on 1/25/17. Review of Resident #2's physician's Progress Notes revealed the resident's last office visit was on 6/15/17. Refer to interview on 8/04/17 at 10:05 am with the Administrator. 3. Review of Resident #3's current FL-2 dated 10/31/16 revealed: -Diagnoses included schizophrenia, anxiety, depression, hypertension, mild mental retardation, and asthma. -There was an order for Albuterol Sulfate 0.083%, inhale every 4 hours as needed. Review of Resident #3's LHPS Evaluations & Quarterly Reviews revealed: -There was an LHPS initial evaluation completed on 8/31/16 with a task for inhalation medication by machine. -There was an LHPS evaluation completed on 11/11/16 with tasks for inhalation medication by machine. -There were no quarterly reviews for February 2017 or May 2017. Interview on 8/04/17 at 4:15 pm with Resident #3 revealed the resident used her albuterol when	C 254		

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C 254	Continued From page 10 she needed it, sometimes at night depending on how much she walked around during the day. Interview on 8/04/17 at 9:25 am with Resident #3's primary care provider revealed the resident's last office visit was on 6/30/17; there were no order changes for Resident #3. Refer to interview on 8/04/17 at 10:05 am with the Administrator. 4. Review of Resident #4's current FL-2 dated 10/24/16 revealed: -Diagnoses included seizure disorder, diabetes, hypertension, and acute bronchitis -There was an order for a FSBS check once a week. Review of Resident #4's LHPS Evaluations & Quarterly Reviews revealed: -There was an LHPS initial evaluation completed on 5/23/16 with a task for collection of FSBS. -There was an LHPS evaluation completed on 8/31/16 and 11/11/16 with task for collection of FSBS. -There were no quarterly reviews for February 2017 or May 2017. Interview on 8/04/17 at 9:25 am with Resident #4's primary care provider revealed: -The resident's last 2 office visits were on 5/04/17 for a routine appointment, no order changes, and 7/10/17 for routine visit and lab work. -Resident #4's Hemoglobin A1C (a test that reveals the average blood sugar level over the previous two-three months) was 6.3 on 7/10/17. Refer to interview on 8/04/17 at 10:05 am with the Administrator.	C 254		

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C 254	Continued From page 11 Interview on 8/04/17 at 10:05 am with the Administrator revealed: -She called and left a message for the LHPS nurse in February 2017 (did not recall date) to remind her the residents' quarterly reviews were due and she wanted to schedule them; there was no response. -There were several attempts in February 2017 to contact the LHPS nurse, but had no response. -She no longer had the contact information for the previous LHPS nurse. -The Administrator starting looking for another nurse to do the quarterly reviews. - Registered nurses she knew did not have the time to do her LHPS quarterly reviews. -After looking, she "quit trying and completely forgot". -The LHPS quarterly reviews were due every 3 months; she had not obtained the last 2 quarterly reviews for residents. -The Administrator was responsible for obtaining the reviews. -She needed to get an LHPS nurse to do the quarterly reviews and would check with her pharmacist for recommendations as soon as possible.	C 254		
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.	C 330		

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C 330	Continued From page 12 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure medications were administered as ordered by the primary care physician to 1 of 3 residents (Resident #2) including a medication to lower blood sugar, a medication for prophylaxis of coronary heart disease and medication for gastro esophageal reflux. The findings are: Observation on 8/3/2017 at 10:00 am upon arrival to the facility revealed there was one staff person and three residents present in the home. Interview with the Housekeeper on 8/3/17 at 1:56 pm revealed: -She had been there since 9:30 am when the Administrator left. -She did not know what time the Administrator would be back. -She did not administer lunch time medications. -Resident #2 did not take any medications at lunch. -She never administered medication. -She did not know what medications residents took because she did not touch any medications. -She was hired as a housekeeper. -Her job was to cook, clean and wash clothes. -She came in around 8:30am and stayed until 3:30pm. -She had been at the facility for 3-4 months. -There had only been 1 other time that she had been at the home all day when the Administrator was out. -She could not recall the last time she had been	C 330		

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C 330	Continued From page 13 there all day alone with the residents. Observation on 8/3/2017 at 2:00 pm revealed the Administrator arrived at the home. Review of Resident #2's FL-2 dated 1/24/17 revealed diagnosis of DM II (type 2 diabetes mellitus), gastro esophageal reflux, cervical disc disorder with myelopathy, muscle weakness generalized dysphagia, oropharyngeal phase, constipation. 1. Review of Resident #2's physician orders revealed an order dated 6/15/17 for Novolog Insulin (medication used to help control blood glucose in people with type 1 and type 2 diabetes) 100 Unit/ML inject 6 units before each meal. Interview with Resident #2 on 8/3/17 at 11:30 am revealed: -He was diabetic. -He had been diabetic for a long time. -He got his blood sugar checked 3 x day. -He got insulin in his arm depending on his blood sugar. -He did not get insulin every day. Interviews with Resident #2 on 8/3/17 at 2:03 pm and 2:15 pm revealed: -He only took insulin if his sugar was high. -He took insulin this yesterday morning (8/2/17) and this morning (8/3/17). -He did not take insulin today at lunch. -He slept more when his sugar was high. -He couldn't get going when it was high. -Some mornings he did not need insulin. -He had been diabetic for about 15 years. -He sometimes took insulin in the afternoon. -He never took insulin at bedtime.	C 330		

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C 330	Continued From page 14 Telephone interview with the Office Manager at Resident #2's Physician's office on 8/3/17 at 2:08 pm revealed: -Resident #2 had been seen on 6/15//17. -Orders were to continue with medication at same doses. -Blood sugar checks to be done three times daily (TID). Review of Resident #2's June 2017 Medication Administration Record (MAR) revealed: -There was a letter "F" in the 11:00 am scheduled time frame 4 times for Novolog Insulin from 6/1/17-6/30/17. -There was a letter "F" in the 5:00 pm scheduled time frame 1 time for Novolog Insulin from 6/1/17-6/30/17. Review of Resident #2's July 2017 MAR revealed: -There was a letter "F" in the 11:00 am scheduled time frame 11 times for Novolog Insulin from 7/1/17-7/31/17. -There was a letter "F" in the 5:00 pm scheduled time frame 3 times for Novolog Insulin from 7/1/17-7/31/17. Interview with the Administrator on 8/3/17 at 2:59 pm revealed: -Resident #2 was not on sliding scale. -Resident #2 got his insulin before each meal. -The letter "F" on the MAR was when the resident was out of the facility. -Resident #2 did not get his Novolog Insulin when he was out of the facility. -She did not take medication with her as she did not plan to be out at lunch. -If she did take the insulin, the resident would have to eat within the required time and that was not always possible. -She did not take lunch and/or snacks with them	C 330		

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C 330	Continued From page 15 on errands. Review of Resident #2's vital sign sheet on 8/4/17 revealed blood sugar checks for the month of July 2017 ranged from 79-224. Interview with Resident #2's primary contact on 8/4/17 at 11:36 am revealed: -Resident #2's diabetes had improved recently and was in check. -She had no concerns about the resident's care. Interview with the Medical Assistant at Resident #2's Physician's office on 8/4/17 at 11:50 am revealed: -The doctor had talked with him multiple times about how important it was to be at the facility to get his insulin as scheduled. -She could not comment on what the outcome was for Resident #2 to miss scheduled insulin. -She would recommend that they take the insulin with them on outings. Interview with the Administrator on 8/4/17 at 2:45 pm revealed: -She had not talked to the physician about missed insulin in July 2017. -She had called the physician's office on 8/3/17 and again on 8/4/17 and had to leave a voicemail. -If no one got back with her, she would make an appointment to follow-up. -She had talked to the physician in the past about missed insulin when the resident would not be there at lunch and the physician had told her as long as he was getting his blood sugar checked 2 times a day he was okay with it. -She did not get this in writing from the physician. -She had not specifically asked about the insulin but the insulin was given at the same time of the blood sugar checks.	C 330		

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C 330	Continued From page 16 -At one time the resident did have an order that was prn (as needed) because of the resident not being in the facility. -There had been no discussion with the physician about changing the insulin and blood sugar orders. -She would talk to the doctor as soon as she could to follow up on this. -She would talk to the doctor to discuss how the medication order could be changed to comply with the prescription per doctor's orders. Refer to interview on 8/3/17 at 2:59 pm with the Administrator. Refer to interview with the Medical Assistant at Resident #2's Physician's office on 8/4/17 at 11:50 am. Refer to interview on 8/4/17 at 2:45 pm with the Administrator. 2. Review of Resident #2's physician orders revealed an order dated 4/25/17 for Aspirin 81 mg daily for prophylaxis of coronary artery disease. Review of Resident #2's Medication Administration Record (MAR) from May 2017-August 2017 revealed: -There were no Aspirin documented as administered from 5/1/17-5/31/17. -There were no Aspirin documented as administered from 6/1/17-6/30/17. -There were no Aspirin documented as administered from 71/17-7/31/17. -There were 3-doses of Aspirin administered daily from 8/1/17-8/3/17. Observation of Resident #2's medication on hand on 8/3/17 at 3:30 pm revealed an opened bottle	C 330		

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C 330	Continued From page 17 of over-the-counter Aspirin. Interview with the Administrator on 8/3/17 at 3:45 pm revealed: -She had been giving Aspirin but had not documented it. -She did not know how long she had been giving the Aspirin. -She did not know why she had not documented giving the Aspirin. Telephone interview with the pharmacist on 8/3/17 at 4:58 pm revealed there was no order for Aspirin in Resident #2's pharmacy record. Refer to interview on 8/3/17 at 2:59 pm with the Administrator. Refer to interview with the Medical Assistant at Resident #2's Physician's office on 8/4/17 at 11:50 am. Refer to interview on 8/4/17 at 2:45 pm with the Administrator. 3. Review of Resident #2's FL2 dated 1/24/17 revealed a physician's order for Reglan 10 MG take 1 tablet 3 times daily for gastro esophageal reflux disease (GERD). Review of Resident #2's June 2017 Medication Administration Record (MAR) revealed there was a letter "F" in the 11:00 am scheduled time 4 times for Reglan 10 MG from 6/1/17-6/30/17. Review of Resident #2's July 2017 MAR revealed: -There was a letter "F" in the 11:00 am scheduled time frame 11 times for Reglan 10 MG from 7/1/17-7/31/17. -There was a letter "F" in the 5:00 pm scheduled	C 330		

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C 330	Continued From page 18 time frame 1 time for Reglan 10 MG from 7/1/17-7/31/17. Interview with the Administrator on 8/3/17 at 2:59 pm revealed: -The letter "F" on the MAR was when they were out of the facility. -Resident #2 did not get his Reglan when they were out of the facility. Observation of Resident #2's medication on hand on 8/3/17 at 3:30 pm revealed: -The Reglan dose pack was empty. -The medication had been filled on 6/20/17, quantity of 90 pills. Interview with the Administrator on 8/3/17 at 3:45 pm revealed: -She was going to order Reglan today (8/3/17). -She had given the last pill today with his morning pills. -She did not know why the Reglan filled on 6/20/17 had not ran out prior to today (8/3/17). -There were probably some left from the last refill and this one did not start on 6/20/17. Telephone interview with the pharmacist on 8/3/17 at 4:58 pm revealed: -Reglan had been filled on 3/3/17, 4/25/17, and 6/20/17 for Resident #2. -Each package had 90 pills. -They would last for 1-month if given as prescribed 3 x day. -She did not know why they had not been refilled monthly. Observation of Resident #2's medication on hand on 8/4/17 at 9:30am revealed the Reglan medication had been delivered and a tablet was documented as administered that morning on the	C 330		

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C 330	Continued From page 19 MAR. Interview with the Medical Assistant at Resident #2's Physician's office on 8/4/17 at 11:50 am revealed: -She was not aware of the Reglan medication as she did not see that listed. -Maybe another doctor prescribed that medication. Interview with the Administrator on 8/4/17 at 11:55 am revealed: -She did not know why the physician's office said they did not see Reglan in their information as it was that doctor that ordered it. -She reviewed Resident #2's record and presented a copy of a prescription signed by the same physician for Reglan. -Resident #2 had not complained about having any stomach problems. -He took Zantac every day for his reflux. -He had not missed many doses of his Reglan. Interview with Resident #2 on 8/4/17 at 1:45 pm revealed: -He had heartburn in the past. -He did not know what medication he took for heartburn. -He had not had any problems with heartburn recently. -He did not know the last time he had problems with heartburn. Refer to interview on 8/3/17 at 2:59 pm with the Administrator. Refer to interview with the Medical Assistant at Resident #2's Physician's office on 8/4/17 at 11:50 am.	C 330		

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C 330	Continued From page 20 Refer to interview on 8/4/17 at 2:45 pm with the Administrator. _____ Interview with the Administrator on 8/3/17 at 2:59 pm revealed: -She was the only employee that administered medication. -She did not take medication with her as she did not plan to be out at lunch. -They went out for appointments for residents, shopping and running errands. -The residents that did not attend day programs typically went with her to run errands. -Resident #2 was the only resident who was not in day program that took lunch time medications. Interview with the Medical Assistant at Resident #2's Physician's office on 8/4/17 at 11:50 am revealed: -She was aware that in the past there had been a problem with Resident #2 not receiving his medication as ordered as he would not be in the facility. -She reported that Resident #2 had a history of leaving the facility on his own and not following the orders. -She was not aware that the staff at the facility would take the resident out and not administer medication. -She did not know if the doctor was aware of this. -The doctor was not in the office again until next week. -She read from Resident #2's visit in April of 2016 that the resident and caregiver were at the appointment to discuss non-compliance. Interview with the Administrator on 8/4/17 at 2:45 pm revealed: -She would have someone in the home when she was not present that was qualified to give	C 330		

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C 330	Continued From page 21 medication. -She would have medications with her on outings to ensure residents receive scheduled medications. The facility failed to assure residents were administered medications as ordered for 1 of 3 residents. This resulted in Resident #2, who was diabetic, not receiving Novolog Insulin as ordered before each meal 5 times in June 2017 and 14 times in July 2017. This failure was detrimental to the health, safety and welfare of Resident #2, and constitutes a Type B Violation. The facility's Plan of Protection dated 8/04/17 revealed: -I (Administrator) will have qualified staff at the facility to administer medications. -I (Administrator) will discuss with the doctor how we can change the medication administration order for Resident #2 for me to comply with the rule per doctors' orders. -Going forward, I will take the residents' medications with me on our outings to ensure residents are receiving scheduled medications. -I will ensure residents are receiving medications per doctors' orders by bring medications with me on outings. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 18, 2017.	C 330		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with	C 912		

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C 912	Continued From page 22 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to assure every resident had the right to receive care and services which were adequate, and in compliance with rules and regulations as related to other staff qualifications and medication administration. The findings are: 1. Based on record review and interview, the facility failed to assure 1 of 2 staff (Staff B) had no substantiated findings listed on the Health Care Personnel Registry (HCPR) upon hire according to G.S. 131E-256. [Refer to Tag C 0145, 10A NCAC 13G .0406 Other Staff Qualifications (Type B Violation)]. 2. Based on record review and interview, the facility failed to assure 1 of 2 staff (Staff B) had a criminal background check in accordance with G. S. 114-19.10 and 131D-40. [Refer to Tag C 0147, 10A NCAC 13G .0406 Other Staff Qualifications (Type B Violation)]. 3. Based on observations, record reviews and interviews, the facility failed to assure medications were administered as ordered by the primary care physician to 1 of 3 residents (Resident #2) including a medication to lower blood sugar, a medication for prophylaxis of coronary heart disease and medication for gastro esophageal reflux. [Refer to Tag C 0330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].	C 912		

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C 932	Continued From page 23	C 932		
C 932	G.S. 131D 4.4A (b) ACH Infection Prevention Requirements 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV,	C 932		

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C 932	Continued From page 24 hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 staff (Administrator) had received the annual state mandated infection control training. The findings are: Review of the Administrator's personnel record revealed: -The Administrator was hired in December of 2011 (no day of the month given) as a Medication Aide (MA). - She became the facility Administrator on 5/07/17. -There was documentation of infection control training on 8/16/12 and 9/12/13. -There were no documentation of infection control training for 2014, 2015, or 2016. Interview on 8/02/17 at 4:50 pm with the Administrator revealed: -She did not know there was no documentation of current infection control training in her personnel record. -She was aware the training was required yearly. -The Administrator had taken another class for infection control training instead of taking the state mandated one (could not remember date). -She received the state training in the past by a pharmacist with the facility pharmacy and would contact the pharmacy to take the next class.	C 932		

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C992	Continued From page 25	C992		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for 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.	C992		

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C992	Continued From page 26 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure examination and screening for the presence of controlled substances was performed for 1 staff (Staff B) who was hired after 10/01/13. The findings are: Review of Staff B's personnel record revealed: -There was no hire date documented for Staff B. -She was hired as a housekeeper, cook, and transport staff. -There was no documentation for a controlled substance evaluation and screening in Staff B's personnel record. Interview on 8/04/17 at 2:40 pm with Staff B revealed: -She was hired in May 2017, but did not remember the date. -Her duties were housekeeping and cooking. -She would take residents to go shopping once a week. -She did not do a drug test for employment at the facility. -She could not remember if she was asked to do a drug test. Interview on 8/04/17 at 2:38 with the Administrator revealed: -She did not obtain a drug screening for Staff B. -She was not aware a drug screening was required for staff. -The Administrator was responsible for obtaining a drug screen for staff.	C992		