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 _____	09/21/2018

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 000	Initial Comments The Adult Care Licensure Section and the Alamance Department of Social Services conducted an annual and follow-up survey on 09/20/18, with an exit via telephone conference on 09/21/18.	C 000		
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 interviews and record reviews, the facility failed to assure physician notification for 1 of 3 sampled residents (Resident #1) of high blood pressure readings with ordered parameters. The findings are: Review of the current FL-2 dated 07/13/18 revealed: -Diagnoses included cerebrovascular accident, hypertension, and coronary artery disease. -There was an order for Amlodipine 10 mg (used to treat high blood pressure) daily and Metprolol 12.5 mg (used to treat high blood pressure) twice daily. -There was an order to check Resident #1's blood pressure (BP) daily. Review of Resident #1's subsequent physician's order dated 07/02/18 revealed instructions to call the provider for systolic BP greater than 150 or diastolic BP greater than 100.	C 246		

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C 246	Continued From page 1 Review of Resident #1's subsequent physician's order dated 08/28/18 revealed instructions to call the provider for systolic BP greater than 150, systolic BP less than 100, or diastolic BP greater than 100. Review of Resident #1's July 2018 Medication Administration Record (MAR) revealed: -There was an entry to check and record BP once a day at 8:00 am. -The BP parameters were not transcribed on the MAR. -The BP readings for July 2018 ranged from 78/73 to 188/77 . -Examples of BP results with readings outside of ordered parameters were as follows: -On 07/04/18 staff documented a BP of 188/77. -On 07/05/18 staff documented a BP of 183/81. -On 07/08/18 staff documented a BP of 169/73. -On 07/18/18 staff documented a BP of 163/77. -On 07/20/18 staff documented a BP of 78/73. -On 07/22/18 staff documented a BP of 165/81. -There was no documentation the provider was notified of the BP readings outside of the ordered parameters. Review of Resident #1's August 2018 MAR revealed: -There was an entry to check and record BP once a day at 8:00 am. -The BP parameters were not transcribed on the MAR. -The BP readings for August 2018 ranged from 83/58 to 219/87. -Examples of BP results with readings outside of ordered parameters were as follows: -On 08/11/18 staff documented a BP of 170/104. -On 08/12/18 staff documented a BP of 187/97. -On 08/13/18 staff documented a BP of 184/84. -On 08/18/18 staff documented a BP of 183/81.	C 246		

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C 246	Continued From page 2 -On 08/19/18 staff documented a BP of 176/85. -On 08/27/18 staff documented a BP of 219/87. -On 08/28/18 staff documented a BP of 191/101. -On 08/30/18 staff documented a BP of 83/58. -On 08/31/18 staff documented a BP of 83/58. -There was no documentation the provider was notified of the BP readings outside of the ordered parameters. Review of Resident #1's September 2018 MAR revealed: -There was an entry to check and record BP once a day at 8:00 am. -The BP parameters were not transcribed on the MAR. -The BP readings for September 2018 ranged from 102/70 to 180/99. -Examples of BP results with readings outside of ordered parameters were as follows: -On 09/02/18 staff documented a BP of 180/70. -On 09/08/18 staff documented a BP of 166/104. -On 09/09/18 staff documented a BP of 153/92. -On 09/12/18 staff documented a BP of 163/98. -On 09/17/18 staff documented a BP of 170/70. -On 09/18/18 staff documented a BP of 161/91. -On 09/19/18 staff documented a BP of 180/99. -On 09/20/18 staff documented a BP of 176/78. -There was no documentation the provider was notified of the BP readings outside of the ordered parameters. The Heart Association recommends normal blood pressures range according to the US Department of Health and Human Services, National Institute of Health is lower than 120/80 mmHg (millimeters of Mercury). Review of Resident #1's record revealed no documentation the facility staff had notified the primary care provider (PCP) for BP parameters	C 246		

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C 246	Continued From page 3 as ordered. Interview with the medication aide (MA) on 09/20/18 at 3:50 pm revealed: -She knew Resident #1 was ordered BP checks daily with parameters to call the PCP. -She knew the difference between the top reading (systolic BP) and bottom reading (diastolic BP). -The MA was responsible for checking the BP. -The MA was responsible for notifying the PCP. -She had not notified the PCP of BP results outside the ordered parameters. Interview with the Administrator on 09/20/18 at 4:30 pm revealed: -She knew Resident #1's PCP had ordered BP to be monitored daily with instructions to notify the PCP with the BP exceeded the parameters. -She knew the facility staff were not notifying the PCP as ordered. -The MA was responsible for checking the BP and notifying the PCP with BP results outside the ordered parameters. Telephone interview with Resident #1's PCP on 09/20/18 at 5:30 pm revealed: -The facility staff had not notified her of Resident #1's BP results outside of ordered parameters. -She expected the facility staff to notify her with systolic BP>150, systolic BP<100, or diastolic BP>100. -An increased BP could put Resident #1 at a higher risk for a stroke. Attempted interview with Resident #1's guardian on 09/21/18 at 10:00 am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	C 246		

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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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by a licensing prescriber for 1 of 3 sampled residents (#1) related to a blood pressure medication, and pain relievers. The findings are: Review of Resident #1's current FL-2 dated 07/13/18 revealed diagnoses included anemia, type II diabetes, renal insufficiency, cerebrovascular accident, hyperlipidemia, hypertension, coronary artery disease, malignant neoplasm of uterus, advanced malignant neoplasm of the ovary, and glaucoma. 1. Review of Resident #1's current FL2 dated 07/13/18 revealed physician's orders for Amlodipine 10 mg once daily (medication used for high blood pressure) and daily blood pressures. Review of Resident #1's July, August and	C 330		

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C 330	Continued From page 5 September 2018 Medication Administration Record (MAR) revealed: -There was an entry for Amlodipine 10 mg tablet once daily scheduled at 8:00 am. -Staff documented Amlodipine 10 mg was administered once daily at 8:00 am from 07/01/18 to 09/20/18. -For the month of July 2018, systolic blood pressure ranged from 78-188 and diastolic blood pressure ranged from 60-81. -For the month of August 2018, systolic blood pressure ranged from 83-219 and diastolic blood pressure ranged from 58-104. -For the month of September 2018, systolic blood pressure ranged from 102-180 and diastolic blood pressure ranged from 60-104. Observation of medications on hand on 09/20/18 at 12:16 pm revealed Amlodipine 10 mg was not available for administration. Interview with a representative from the contracted pharmacy on 09/20/18 at 12:20 pm revealed: -The Amlodipine 10 mg was last filled and dispensed on 07/10/18 for 30 tablets. -The facility had not notified the pharmacy Amlodipine 10 mg needed to be refilled. -The facility would have ran out of Amlodipine 10 mg tablets on 08/10/18. Interview with a medication aide (MA) on 09/20/18 at 12:30 pm revealed: -She did not know Amlodipine 10 mg was not available for administration. -She did not know she had not been administering the Amlodipine. -She did not know when the Amlodipine 10 mg was last administered.. -She did not know why the Amlodipine 10 mg was	C 330		

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C 330	Continued From page 6 not called into the pharmacy. Interview with the Administrator on 09/20/18 at 1:00 pm revealed: -She did not know Resident #1 was not receiving Amlodipine 10 mg as ordered. -She did not know staff had not called the pharmacy to have the medication refilled. Interview with Resident #1's PCP on 09/20/18 at 5:30 pm revealed: -She did not know Resident #1 was not receiving Amlodipine 10 mg as ordered. -She expected staff to administer Amlodipine 10 mg as ordered. -Not receiving the Amlodipine 10 mg as ordered could cause increased blood pressure. -She did not know the systolic BP got as high as 219. Attempted interview with Resident #1's guardian on 09/21/18 at 10:00 am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to interview with the contracted pharmacy on 09/20/18 12:25 pm Refer to interview with a MA on 09/20/18 at 12:35 pm. Refer to interview with the Administrator on 09/20/18 at 1:05 pm. 2. Review of Resident #1's current FL2 dated 07/13/18 revealed a physician's order for Sertraline Hcl 50 mg once daily (medication used to treat depression).	C 330		

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C 330	Continued From page 7 Review of Resident #1's July, August and September 2018 Medication Administration Record (MAR) revealed: -There was an entry for Sertraline Hcl 50 mg tablet once daily scheduled at 8:00 pm. -Staff documented Sertraline Hcl 50 mg was administered once daily at 8:00 pm from 07/01/18 to 09/20/18. Observation of medications on hand on 09/20/18 at 12:16 pm revealed Sertraline Hcl 50 mg was not available for administration. Interview with a representative from the contracted pharmacy on 09/20/18 at 12:20 pm revealed: -The Sertraline Hcl 50 mg was last filled and dispensed on 07/10/18 for 30 tablets. -The facility had not notified the pharmacy Sertraline Hcl 50 mg needed to be refilled. -The facility would have ran out of Sertraline Hcl 50 mg tablets on 08/10/18. -The pharmacy did not have a record of the Sertraline Hcl 50 mg being returned. -The Sertraline was an active order and no discontinue order had been received. Interview with a medication aide (MA) on 09/20/18 at 12:30 pm revealed: -She knew Sertraline Hcl 50 mg was not available for administration. -She had not given Sertraline Hcl 50 mg since the resident was admitted to the facility because she thought the medication was discontinued. -She remembered seeing an order to discontinue but was unable to produce the order. Interview with the Administrator on 09/20/18 at 1:00 pm revealed:	C 330		

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C 330	Continued From page 8 -Resident #1 was ordered Sertraline due to the diagnoses of depression. -She did not know Resident #1 was not receiving Sertraline Hcl 50 mg as ordered. -She did not know staff had not called the pharmacy to have the medication refilled. Interview with Resident #1's PCP on 09/20/18 at 5:30 pm revealed: -She did not know Resident #1 was not receiving Sertraline Hcl 50 mg as ordered. -She expected staff to administer Sertraline Hcl 50 mg as ordered. -She had not discontinued the Sertraline Hcl 50 mg. -Not receiving the Sertraline Hcl 50 mg as ordered could cause increased depression and change in mood. Attempted interview with Resident #1's guardian on 09/21/18 at 10:00 am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to interview with the contracted pharmacy on 09/20/18 12:25 pm Refer to interview with a MA on 09/20/18 at 12:35 pm. Refer to interview with the Administrator on 09/20/18 at 1:05 pm. 3. There was a physician's order on the current FL2 dated 07/13/18 for Acetaminophen (Tylenol) 500 mg twice daily (medication used for pain reliever).	C 330		

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C 330	Continued From page 9 Review of Resident #1's July, August and September 2018 Medication Administration Record (MAR) revealed: -There was an entry for Acetaminophen (Tylenol) 500 mg tablet, one tablet twice daily scheduled at 8:00 am and 8:00 pm. -Staff documented Acetaminophen (Tylenol) 500 mg was administered twice daily at 8:00 am and 8:00 pm from 07/01/18 to 09/20/18. Observation of medications on hand on 09/20/18 at 12:16 pm revealed Acetaminophen (Tylenol) 500 mg tablets were not available for administration. Interview with a representative from the contracted pharmacy on 09/20/18 at 12:20 pm revealed: -The Acetaminophen (Tylenol) 500 mg was dispensed on 07/10/18 for 60 tablets. -The Acetaminophen was scheduled to be completed by 08/10/18, if administered as ordered twice daily. -The pharmacy did not receive a refill request from the facility. Interview with a medication aide (MA) on 09/20/18 at 12:30 pm revealed: -She did not know Acetaminophen (Tylenol) 500 mg was not available for administration. -She did not know when the Acetaminophen 500 mg was last administered. -She did not know why the Acetaminophen 500 mg was not called into the pharmacy. Interview with the Administrator on 09/20/18 at 1:00 pm revealed: -She did not know Resident #1 was not receiving Acetaminophen (Tylenol) 500 mg as ordered. -She did not know staff had not called the	C 330		

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C 330	Continued From page 10 pharmacy to have the medication refilled. Interview with Resident #1's primary care provider's (PCP) on 09/20/18 at 5:30 pm revealed: -She did not know Resident #1 did not receive Acetaminophen (Tylenol) as ordered. -The Acetaminophen was ordered for mild pain. -She expected staff to administer Acetaminophen (Tylenol) as ordered. Attempted interview with Resident #1's guardian on 09/21/18 at 10:00 am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to interview with the contracted pharmacy on 09/20/18 12:25 pm Refer to interview with a MA on 09/20/18 at 12:35 pm. Refer to interview with the Administrator on 09/20/18 at 1:05 pm. 4. Review of Resident #1's current FL2 dated 07/13/18 revealed a physician's order for Aspirin 325 mg once daily (medication used for pain reliever/inflammation). Review of Resident #1's July, August and September 2018 Medication Administration Record (MAR) revealed: -There was an entry for Aspirin 325 mg tablet once daily scheduled at 8:00 am. -Staff documented Aspirin 325 mg was administered once daily at 8:00 am from 07/01/18 to 09/20/18.	C 330		

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C 330	Continued From page 11 Observation of medications on hand on 09/20/18 at 12:16 pm revealed Aspirin 325 mg tablets were not available for administration. Interview with a representative from the contracted pharmacy on 09/20/18 at 12:20 pm revealed: -The Aspirin 325 mg was last filled and dispensed on 07/10/18 for 30 tablets. -The facility had not notified the pharmacy Aspirin 325 mg needed to be refilled. -The facility would have ran out of Aspirin 325 mg tablets on 08/10/18. Interview with a medication aide (MA) on 09/20/18 at 12:30 pm revealed: -She did not know Aspirin 325 mg was not available for administration. -She did not know when the Aspirin 325 mg was last administered. -She did not know why the Aspirin 325 mg was not called into the pharmacy. Interview with the Administrator on 09/20/18 at 1:00 pm revealed: -She did not know Resident #1 was not receiving Aspirin 325 mg as ordered. -She did not know staff had not called the pharmacy to have the medication refilled. Interview with Resident #1's PCP on 09/20/18 at 5:30 pm revealed: -She did not know Resident #1 was not receiving Aspirin 325 mg as ordered. -She expected staff to administer Aspirin 325 mg as ordered. Attempted interview with Resident #1's guardian on 09/21/18 at 10:00 am was unsuccessful.	C 330		

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C 330	Continued From page 12 Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to interview with the contracted pharmacy on 09/20/18 12:25 pm Refer to interview with a MA on 09/20/18 at 12:35 pm. Refer to interview with the Administrator on 09/20/18 at 1:05 pm. _____ Interview with the contracted pharmacy on 09/20/18 12:25 pm revealed: -The pharmacy managed the facility's MARs. -The pharmacy dispensed all of Resident #1's medication. -The facility was required to call each month to have medication filled. -The facility was not set up for auto or cycle fill of medications. Interview with a MA on 09/20/18 at 12:35 pm revealed: -When she passed medications, she pulled the bubble packs out of the basket and gave the medication according to the instructions on the bubble pack. -She did not compare the MAR to the bubble packs when administering medications. -She then documented the medications that were due to be given on the MAR. -When a medication was close to running out she was required to call the pharmacy and request the medication be refilled. -She did not realize the medications were not available because she did not compare the MAR to the bubble packs during medication pass.	C 330		

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C 330	Continued From page 13 Interview with the Administrator on 09/20/18 at 1:05 pm revealed: -She expected staff to administer medications as ordered. -She expected staff to call the pharmacy for medication refills prior to the medication running out. -She expected staff to compare the MAR to medications during medication pass. -She did know the facility was not set up for autofill. -Staff were expected to pay attention to how much medication was left in the bubble pack and call the pharmacy to refill medication when there was 3 days left of medication. The facility failed to administer medications as ordered to Resident #1, including two pain relievers, a medication for depression, and a blood pressure medication. This failure placed the resident at risk for increased pain, depression, and high blood pressure. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/21/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, November 5, 2018.	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:	C 912		

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 _____	09/21/2018

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 912	Continued From page 14 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by a licensing prescriber for 1 of 3 sampled residents (#1) related to a blood pressure medication, and pain relievers. [Refer to Tag 0330, .1004(a) Medication Administration (Type B Violation)].	C 912		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount	C 934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 934	Continued From page 15 determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had completed the annual state approved infection control training. The findings are: Review of Staff C, medication aide/supervisor-in-charge's personnel record revealed: -Staff C was hired on 12/26/09. -There was documentation of annual infection control training dated 09/17/16. Interview with the Administrator on 09/20/18 at 4:30 pm revealed: -Infection control training was provided yearly. -She was responsible for scheduling annual infection control training. -She knew the state approved infection control training was supposed to be completed every year. -She was planning to have an infection control training before the end of the year. -She did not know Staff C did not have a current infection control training certificate in her personnel record. Attempted interview with Staff C on 09/20/18 at 2:30 pm was unsuccessful.	C 934		