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	FCL074041	A. BUILDING: _____ B. WING _____	12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMIE'S FAMILY CARE HOME II	110 PEARL DR GREENVILLE, NC 27834

(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 12/13/18 - 12/14/18.	C 000		
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. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to assure the Electronic Medication Administration Records (eMARs) were accurate to include the initials of the medication aide (MA) which administered the medications for 3 of 3 sampled residents (Resident #1, #2, #3) with orders for medications to be administered at 8:00am. The findings are: Interview with the Administrator on 12/13/18 at 11:25am revealed: -All staff had their own login and password for using the eMAR system. -When the staff logged in to the eMAR, and administered medications, it automatically recorded the staff's initials as having given the medication.	C 341		

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-All staff had been trained to not share their login and password information with anyone
-Her family member was the "administrator" of the eMAR system, which meant she was the only person who could add people to the eMAR system.
-Her family member was out of town and could not add Staff A to the eMAR system until she returned on 12/15/18.
-She told Staff A to use her login and initials for signing the medications on the eMAR until Staff A was added to the system.
-Staff A administered the 8:00am medications to all residents on 12/04/18 and 12/11/18, using the Administrator's login and initials.

Interview with a medication aide (MA) on 12/13/18 at 1:30pm revealed:
-She started working at the facility on 10/30/18 as a medication aide (MA) in training working with the Administrator.
-Her last day working and training with the Administrator was 12/03/18.
-She worked by herself on 12/04/18 and 12/11/18, each day from 7:00am - 2:00pm, responsible for the four residents who resided at the facility.
-She administered the 8:00am medications to the four residents on 12/04/18 and 12/11/18.
-She used the Administrator's login and initials for signing the medications on the eMAR since the Administrator told her to do that until she got her name added to the eMAR system.

1. Review of Resident #1's current FL-2 dated 08/28/18 revealed:
-Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, congestive heart failure and gastroesophageal reflux disease.
-A physician's order for Breo Ellipta 100-25 mcg;

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inhale one puff daily for chronic obstructive pulmonary disease was given.
-A physician's order Famotidine 20mg tablet; take one twice a day for reflux.
-A physician's order Furosemide 20 mg tablet; take one daily for edema.
-A physician's order Januvia 25 mg tablet; take one daily for diabetes.
-A physician's order Serevent Diskus 50 mcg inhale one puff twice a day for shortness of breath.
-A physician's order Therems-M tablet; take one daily for supplement.

Review of Resident #1's electronic medication administration record (eMAR) revealed the following medications were documented as administered on 12/04/18 and 12/11/18 at 8:00am by Staff A using the Administrator's initials:
-Breo Ellipta 100-25 mcg; inhale one puff daily for chronic obstructive pulmonary disease was documented as administered.
-Famotidine 20mg tablet; take one twice a day for reflux was documented as administered.
-Furosemide 20 mg tablet; take one daily for edema was documented as administered.
-Januvia 25 mg tablet; take one daily for diabetes was documented as administered.
-Serevent Diskus 50 mcg inhale one puff twice a day for shortness of breath was documented as administered.
-Therems-M tablet; take one daily for supplement was documented as administered.

Interview with Resident #1 on 12/14/18 at 12:45pm revealed Staff A administered her medications on the days she worked.

2. Review of Resident #2's current FL-2 dated 09/04/18 revealed:

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-Diagnoses included hypertension, hyperlipidemia, and back and neck pain.
-A physician's order Amlodipine Besylate 10 mg tablet; take one daily.
-A physician's order Aspirin Child 81mg chew; take one daily.
-A physician's order Losartan Potassium 100 mg tablet; take one daily.
-A physician's order Multivitamin tablet; take one daily.
-A physician's order Potassium CL ER 10 meq tablet; take one daily.

Review of Resident #2's electronic medication administration record (eMAR) revealed the following medications were documented as administered on 12/04/18 and 12/11/18 at 8:00am by Staff A using the Administrator's initials:
-Amlodipine Besylate 10 mg tablet; take one daily was documented as administered.
-Aspirin Child 81mg chew; take one daily was documented as administered.
-Losartan Potassium 100 mg tablet; take one daily was documented as administered.
-Multivitamin tablet; take one daily was documented as administered.
-Potassium CL ER 10 meq tablet; take one daily was documented as administered.

Interview with Resident #2 on 12/13/18 at 9:30am revealed Staff A administered her medications on the days she worked.

3. Review of Resident #3's current FL-2 dated 06/27/18 revealed:
-Diagnoses included hypertension, hyperlipidemia, Alzheimer's disease, chronic obstructive pulmonary disease, hypothyroidism, and schizophrenia.
-A physician's order Clozapine 100 mg tablet;

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take one every morning.
-A physician's order Fiber Tablet 625mg; take twice a day.
-A physician's order Fluoxetine HCL 40 mg capsule; take one daily.
-A physician's order Levothyroxine 50 mcg tablet; take every morning 30 minutes before food.
-A physician's order Lisinopril 2.5mg tablet; take one daily.
-A physician's order Omeprazone DR 40 mg capsule; take one daily.
-A physician's order Vitamin B-12 1,000 mcg tablet; take one daily.
-A physician's order Vitamin C 250mg tablet; take one daily.

Review of Resident #3's electronic medication administration record (eMAR) revealed the following medications were documented as administered on 12/04/18 and 12/11/18 at 8:00am by Staff A using the Administrator's initials:
-Clozapine 100 mg tablet; take one every morning was documented as administered.
-Fiber Tablet 625mg; take twice a day was documented as administered.
-Fluoxetine HCL 40 mg capsule; take one daily was documented as administered.
-Levothyroxine 50 mcg tablet; take every morning 30 minutes before food, was documented as administered.
-Lisinopril 2.5mg tablet; take one daily was documented as administered.
-Omeprazone DR 40 mg capsule; take one daily was documented as administered.
-Vitamin B-12 1,000 mcg tablet; take one daily was documented as administered.
-Vitamin C 250mg tablet; take one daily was documented as administered.

Interview with Resident #3 on 12/14/18 at

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C 341	Continued From page 5 12:30pm revealed Staff A administered her medications on the days she worked.	C 341		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if	C935		

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applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
Based on interviews, and record reviews, the facility failed to assure 1 of 3 sampled medication aides (Staff A) had completed the 5 hour state approved medication administration course prior to being allowed to administer medications.

The findings are:

Review of Staff A's (medication aide) personnel record revealed:
-Staff A was hired at the facility on 10/30/18.
-There was no documentation she had completed the 5 hour state approved medication administration course.
-She completed a medication clinical skills validation checklist on 12/04/18.

Interview with three residents on 12/13/18 at 9:30am and 12/14/18 at 12:30pm-12:50pm revealed:
-Whoever was working at the facility was the person who gave them medications.
-Staff A administered the medications to all residents at the facility on the days she worked.

Interview with the Administrator on 12/13/18 at 11:25am revealed:
-She was responsible for maintaining the staff personnel records.
-Staff A had been administering medications

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since she had completed her orientation and had been working alone on 12/04/18.
-Staff A worked 2-4 days per week 7:00am-2:00pm.
-Staff A administered the 8:00am medications to all residents on 12/04/18 and 12/11/18.
-Staff A used the Administrator's login and initials for signing the medications on the Electronic Medication Record (eMAR) since she did not have "administrative" access to add Staff A to the eMAR system.
-Staff A had completed her medication clinical skills checklist on 12/04/18.
-Staff A was scheduled to take the 15 hour approved medication administration course and test on 12/27/18.
-She was not aware that Staff A had to take the 5 hour approved medication administration course prior to administering medications.
-She thought the medication clinical skills checklist was all that was needed to administer medications until she took the class.
-She would not allow Staff A to administer medications until she had completed the medication administration training.

Interview with Staff A on 12/13/18 at 1:30pm revealed:
-She started working at the facility on 10/30/18 as a medication aide (MA) in training working with the Administrator.
-Her last day working and training with the Administrator was 12/03/18.
-She worked by herself on 12/04/18 and 12/11/18, each day from 7:00am - 2:00pm, responsible for the four residents who resided at the facility.
-She administered the 8:00am medications to the four residents on 12/04/18 and 12/11/18.
-She used the Administrator's login and initials for signing the medications on the Electronic

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C935	Continued From page 8 Medication Record (eMAR) since the Administrator told her to do that until she got her name added to the eMAR system. -She did not know that she had to take the 5 hour state approved medication administration course prior to administering medications. -She was scheduled for the 15 hour medication class on 12/27/18 and completed the medication clinical skills checklist on 12/04/18. -She would not administer any medications until she completed the approved medication administration course.	C935		